

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL



APRIL 1950

VOL. L IV

No. 4

CONTENTS

Editorial	74	Correspondence	92
A New Robe for Rahere, by Reginald M. Vick, O.B.E.	76	Preparation of Material for the Press, by J.L.T.	92
Impromptu in Extremis, by E.A.B.	83	The Wessex Rahere Club	92
Principles in the Treatment of Athletic Injuries, by R. Salisbury Woods	84	Sport	93
The Students' Union Annual Ball, by H.B.	89	Ward Round Times	94
Pitfalls in Gastroenterological Diagnosis, by Indira	90	Times for Attendance at Out-patient and Special Departments	95
		Book Reviews	96

- The same high standard of security and service which characterises "Car & General" Motor Policies applies to every other class of business transacted by the Company. A 'phone call (WHitehall 6161) or a postcard will bring you full information by return.

**PERSONAL
ACCIDENT
BURGLARY
GOLFERS
Comprehensive
Home
FIRE**

CAR & GENERAL INSURANCE CORPORATION LTD.
83 PALL MALL, LONDON, S.W.1

The House of Churchill

TEXTBOOK OF GYNAECOLOGY

By WILFRED SHAW, M.A., M.D., F.R.C.S., F.R.C.O.G.
Fifth Edition. 4 Plates and 292 Text-figures. 25s.

Also by Mr. WILFRED SHAW

TEXTBOOK OF MIDWIFERY

Third Edition. 4 Plates and 235 Text-figures. 22s. 6d.

CHEMICAL METHODS IN CLINICAL MEDICINE

By G. A. HARRISON, M.D., F.R.I.C. Third Edition.
5 Coloured Plates and 120 Text-figures. 40s.

RECENT ADVANCES IN ANAESTHESIA AND ANALGESIA: Including Oxygen Therapy

By C. LANGTON HEWER, M.B., B.S., M.R.C.P., F.F.A.R.C.S. Sixth Edition. 149 illustrations. 21s.

RECENT ADVANCES IN PATHOLOGY

By G. HADFIELD, M.D., F.R.C.P., and L. P. GARROD, M.A., M.D., F.R.C.P. Fifth Edition. 60 Illustrations. 21s.

RECENT ADVANCES IN THE PHYSIOLOGY OF VISION.

By HAMILTON HARTRIDGE, M.A., M.D., Sc.D., F.R.S. 236 illustrations. 25s.

ANAESTHETICS FOR MEDICAL STUDENTS

By GORDON S. OSTLER, M.B., M.R.C.S. D.A.(Eng). 7s. 6d.

HUMAN PHYSIOLOGY

By F. R. WINTON, M.D., D.Sc., and L. E. BAYLISS, Ph.D. Third Edition. 248 Illustrations. 25s.

PRINCIPLES OF HUMAN PHYSIOLOGY (Starling)

Tenth Edition. By C. LOVATT EVANS, D.Sc., F.R.C.P., F.R.S. 693 Illustrations. 42s.

BIOCHEMISTRY FOR MEDICAL STUDENTS

By W. V. THORPE, M.A., Ph.D. Fourth Edition. 36 Illustrations. 18s.

SYNOPSIS OF REGIONAL ANATOMY

By T. B. JOHNSTON, C.B.E., M.D. Sixth Edition. 17 Illustrations. 18s.

ELEMENTARY ANATOMY AND PHYSIOLOGY

By JAMES WHILLIS, M.D., M.S., F.R.C.S. Third Edition. 108 Illustrations. 16s.

BACTERIOLOGICAL TECHNIQUE: A Guide for Medical Laboratory Technicians

By WALLACE W. W. McEWEN, A.I.M.L.T., F.R.M.S. 75 Illustrations. 15s.

PRACTICAL SECTION CUTTING AND STAINING

By E. C. CLAYDEN, F.I.M.L.T. 21 Illustrations. 9s.

APPLIED MEDICINE: Descriptive Cases and Cases demonstrated at the Bedside by Question and Answer.

By G. E. BEAUMONT, M.A., D.M., F.R.C.P., D.P.H. 74 Illustrations. 30s.

"A first class production worthy of the best British tradition" MEDICAL PRESS

OPHTHALMIC MEDICINE

By J. H. DOGGART, M.A., M.D., F.R.C.S. 28 Coloured Plates and 87 Text-figures. 32s.

ESSENTIALS OF ORTHOPAEDICS

By PHILIP WILES, M.S., F.R.C.S., F.A.C.S. 7 Coloured Plates and 365 Text-figures. 42s.

RECENT ADVANCES IN PHARMACOLOGY

By J. M. ROBSON, M.D., D.Sc., F.R.S.(Ed.), and C. A. KEELE, M.D., F.R.C.P. 46 Illustrations. 24s.

PRACTICAL PROCEDURES IN CLINICAL MEDICINE

By R. I. S. BAYLISS, M.A., M.D., M.R.C.P. 62 Illustrations. 25s.

THE DIABETIC LIFE: Its Control by Diet and Insulin

By R. D. LAWRENCE, M.D., F.R.C.P. Fourteenth Edition. 18 Illustrations. 10s. 6d.

A SHORT TEXTBOOK OF MIDWIFERY

By G. F. GIBBERD, M.S., F.R.C.S., F.R.C.O.G. Fourth Edition. 195 Illustrations. 21s.

ANTENATAL AND POSTNATAL CARE

By F. J. BROWNE, M.D., F.R.C.S. Edin., F.R.C.O.G. Sixth Edition. 90 Illustrations. 25s.

DISEASES OF INFANCY AND CHILDHOOD

By WILFRID SHELDON, M.D., F.R.C.P. Fifth Edition. 8 Plates and 143 Text-figures. 30s.

A HANDBOOK OF OPHTHALMOLOGY

By HUMPHREY NEAME, F.R.C.S., and F. A. WILLIAMSON-NOBLE, F.R.C.S. Sixth Edition. 12 plates (containing 46 coloured illustrations) and 189 text-figures. 21s.

CLINICAL ENDOCRINOLOGY

By LAURENCE MARTIN, M.A., M.D., F.R.C.P., and MARTIN HYNES, M.D., M.R.C.P. 32 Illustrations. 15s.

ESSENTIALS FOR FINAL EXAMINATIONS IN MEDICINE

By J. de SWIET, M.D., M.R.C.P. Third Edition. 9s.

THE M.B., B.S. FINALS, 1932-45

By F. MITCHELL-HEGGS, M.B., F.R.C.S. Third Edition. 8s. 6d.

A TEXTBOOK OF SURGICAL PATHOLOGY

By C. F. W. ILLINGWORTH, C.B.E., Ch.M., F.R.C.S. (Edin.), and B. M. DICK, M.B., F.R.C.S. (Edin.). Sixth Edition. 317 Illustrations. 45s.

Also by Professor C. F. W. ILLINGWORTH:

A SHORT TEXTBOOK OF SURGERY

Fourth Edition. 12 Plates and 227 Text-figures. 30s.

LEWIS'S OF GOWER STREET, LONDON, W.C.1

A SHORT PRACTICE OF SURGERY.

By HAMILTON BAILEY, F.R.C.S., F.I.C.S., and R. J. McNEIL LOVE, M.S. (Lond.), F.R.C.S., F.I.C.S. Eighth edition in five parts. Not sold separately. Also available in one volume, same price. 52s. 6d. net

HUMAN HISTOLOGY. A Guide for Medical Students

By E. R. A. COOPER, M.D., M.Sc. With a Foreword by F. WOOD JONES, F.R.S., F.R.C.S. Second edition. With 5 coloured plates and 257 illustrations in the Text. Demy 8vo. 27s. 6d. net; postage 9d

ELEMENTARY PATHOLOGICAL HISTOLOGY

By W. G. BARNARD, F.R.C.P. With 181 illustrations, including 8 coloured, on 54 plates. Crown 4to. Reprinted with additional matter. 12s. 6d. net; postage 7d.

LANDMARKS AND SURFACE MARKINGS OF THE HUMANE BODY

By L. BATHE RAWLING, M.B., B.C. (Cantab.), F.R.C.S. (Eng.). Eighth edition. B.M.A. terminology. British revision. With 36 illustrations. Demy 8vo. 12s. net; postage 7d.

OBSTETRICS AND GYNAECOLOGY. A Synoptic Guide to Treatment.

By E. M. W. DOBBIE, M.A., M.B., D.M.R.E., F.R.C.S. With 22 illustrations. Demy 8vo. 20s. net; postage 9d.

NOTABLE NAMES IN MEDICINE AND SURGERY

By HAMILTON BAILEY, F.R.C.S., and W. J. BISHOP, F.L.A. Second Edition. Illustrated. Crown 8vo. 15s. net. postage 6d.

COMMON SKIN DISEASES

By A. C. ROXBURGH, M.D., F.R.C.P. Eighth Edition. With 8 coloured plates and 212 illustrations in the text. Demy 8vo. 21s. net; postage 9d.

FRACTURES AND DISLOCATIONS IN GENERAL PRACTICE

By JOHN P. HOSFORD, M.S.Lond., F.R.C.S. Second Edition, revised by W. D. COLTART, F.R.C.S. With 87 illustrations. Demy 8vo. 21s. net.

MINOR SURGERY

By R. J. McNEILL LOVE, M.S.Lond., F.R.C.S.Eng. Third edition. With 221 illustrations. Crown 8vo. 22s. 6d. net; postage 9d.

THE THEORY AND PRACTICE OF MASSAGE AND MEDICAL GYMNASTICS

By B. M. GOODAL-COPESTAKE. Seventh Edition. Revised with 147 illustrations. Demy 8vo. 21s. net; postage 9d.

PRACTICAL HISTOLOGY FOR MEDICAL STUDENTS

By D. T. HARRIS, D.Sc., M.D. Fourth Edition. With 2 plates (1 coloured). Crown 4to. 12s. 6d. net; postage 7d.

THE DIAGNOSIS OF THE ACUTE ABDOMEN IN RHYME

By "ZETA". Second edition. With drawings by Peter Collingwood. Crown 8vo. 6s. net; postage 4d.

Lewis's publications are obtainable of all Booksellers

LONDON: 136 GOWER STREET, W.C.1

H. K. LEWIS & Co. Ltd.

BOOKSELLING DEPARTMENT A large stock of textbooks and recent literature in all branches of Medicine and Surgery available. Catalogues on request. Please state interests.

FOREIGN DEPARTMENT Select stock available. Books not in stock obtained to order under Board of Trade Licence.

SECOND-HAND DEPARTMENT Large stocks of recent editions. Old and rare books sought for and reported. 140 GOWER STREET, LONDON, W.C.1

LENDING LIBRARY Annual Subscription from **ONE GUINEA** PROSPECTUS post free on application. Bi-monthly list of **NEW BOOKS** and **NEW EDITIONS** added to the Library post free regularly on request. Subscriptions at **SPECIAL RATES FOR STUDENTS** at the Medical Schools in London and the Provinces. Terms on application.

H. K. LEWIS & Co. Ltd.,

136 GOWER STREET, LONDON, W.C.1

Telephone:
EUScon 4282 (4 lines)

Business Hours:
9 a.m. to 5 p.m., Saturdays to 1 p.m.,

Telegrams:
Publicavit, Westcent, London



Contributions to Clinical Research

ONE of a series outlining some of the activities of Boots Pure Drug Co. Ltd., Nottingham, England.

CLINICAL TRIALS



CONSTANT LIAISON is maintained with doctors and teaching hospitals for clinical trials of new products prepared by the Boots organisation. If any difficulties are reported at this stage, the product is modified. Further clinical trials are then made, to ensure that the modifications have the desired effect.

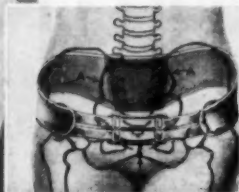
The following are other spheres in which Boots contribute towards Clinical Research: Research Committees, Laboratory Work, Field Research, Development and Production, Information Service.

BOOTS PURE DRUG COMPANY LIMITED NOTTINGHAM ENGLAND



A SPENCER SUPPORT compensates for Sacro-iliac or Lumbo-Sacral Instability

The reason why Spencer Supports are so effective is: Each Spencer Support is *individually designed*, cut and made at our Manufactory at Banbury after a description of the patient's body and posture has been recorded—and 15 or more measurements have been taken. This assures the doctor that each patient will receive the proper design to aid his treatment; that the support will improve body mechanics and will fit with the precision and comfort necessary.



Spencer Sacro-iliac Support. Shadowgraph shewing position of inner pelvic band and pad. The immobilizing bandage is 3" wide and fits closely around the pelvis exactly between the trochanter and the iliac crest, and incorporates a wedge shaped pad 5" x 4", which, bevelled at the edges, rests over the sacrum. The bandage can be adjusted to any degree of tightness required and is instantly adjustable (from OUTSIDE the support) by means of flat, self-locking slides.

The Spencer you prescribe for Sacro-iliac or Lumbo-Sacral Instability will be designed to

- ★ Provide co-operation of abdominal and back support to modify any abnormal tilt of pelvis. Thus body mechanics are improved.
- ★ Grip pelvic girdle so effectively, stabilization of pelvis will result.
- ★ Immobilize the lower back when it is desirable to inhibit movement of specific parts. (Immobilization of entire back is provided when prescribed).

Spencer Supports vary all the way from flexibility to rigidity, depending upon the requirements. Comfortable to sleep in when continuous day and night support is necessary.

SPENCER (BANBURY) LTD.

Consultant Manufacturers of

Surgical and Orthopaedic Supports

SPENCER HOUSE

BANBURY

OXFORDSHIRE

Tel. Banbury 2265

Spencer copyright designs are original and distinctive and for more than 20 years have been recognised by the Medical Profession as a symbol of effective control for abdomen, back and breasts.

BEWARE OF IMITATIONS. Spencer (Banbury) Ltd. regret the necessity of issuing warning to beware of copies and imitations. Look for the **SPENCER LABEL** stitched in the Spencer Support and ensure that it is a genuine Spencer Support and not a so-called copy.

Trained Fitters available throughout the Kingdom

Copyright: Reproduction in whole or in part is prohibited except with the written permission of S (B) Ltd

S. B. 4/50

ST. BARTHOLOMEW'S



HOSPITAL JOURNAL

Vol. LIV

APRIL, 1950

No. 4

EDITORIAL OR ESSAY?

We recently received enquiries as to when the JOURNAL editorials ceased being editorials and became essays on subjects often remote from medical and Hospital interest. To answer this, a brief review of the evolution of the Bart.'s editorial is necessary.

The JOURNAL was founded in 1893 in the face of considerable opposition, and under an extract from Horace were stated the objects of the new Editor: to put on permanent record clinical work done in the Hospital: to promote and extend the feeling of *esprit de corps* among students: to record clinical lectures which many students were unable to attend: to give publicity to anything original in the way of articles, verse and drawings, and to keep up the interest of old students in the doings of those at Hospital. They are objects as true now as then, though perhaps the idea of the JOURNAL raising a whirlwind of *esprit de corps* was a little ambitious.

In this first number was an account of an outbreak of cholera in Bart.'s, and also an article by "Our Comical Correspondent"—an office for which we should be grateful to receive applications.

These early editorials were purely a series of notes on Hospital occurrences and problems during the month, Rugger receiving considerable attention. Players were criticised for turning out for clubs other than the Hospital, and there appeared the title "Football as a moral agent." A patient at St. Thomas' Hospital had leapt out of bed and drunk a bottle of nitric acid intended for testing urines: canyassing on behalf of candidates for the post of Junior Ophthalmic Surgeon aroused intense enthusiasm—their election manifestos must have been interesting.

During the whole of 1897 the Editor declined to commit himself to paper—an attitude warmly commended by the present holder of that office. Later, in 1901, not only was there no editorial but there was no Editor, and a plaintive appeal for a new one was published. Since at that time the post was held for two years, not six months as now, it was a task not lightly undertaken.

In 1910 came notes on the death of Florence Nightingale and the election of Dr. —now Viscount—Addison to Parliament—had the B.B.C. then been in existence, he might well have been the prototype of our present Radio Doctor. The JOURNAL was reduced in size during the First World War, editorial efforts feeling the pinch also. From the end of the war until 1937 these brief notes continued, enlivened in 1924 and following years by the era of Bart.'s predominance in the Hospitals' Rugger Cup.

Then in 1937 the editorial as we know it was evolved, with single subjects varying from poor attendance at Abernethian Society meetings to the constantly recurring appeals for more material. The "tone" began to rise—an editorial on "Cynicism, Fatalism and Hedonism," with Plutarch getting more than a passing mention, came with "A Ciceronian Soliloquy on *Hirudo*: the Cataline"!.

In recent years two schools of thought have become apparent. On the one hand are mellifluous metaphysical meanderings in the realm of Higher Medicine; on the other, commentaries on the outstanding events of the day. The former school has predominated, and, except that it comes first, the editorial has been indistinguishable from the rest of the matter. The fact which causes the division is that 60 per cent. of the readers of

the JOURNAL—the paying readers incidentally—have left the Hospital and it is they who are the targets for the erudite editorial. The downtrodden proletarian 40 per cent. have been expected to gather their crumbs of information from the remainder of the JOURNAL.

Let it now be stated that the object of the present staff is to keep its feet as close as

possible to terra firma, without prejudice to the "tone" of the JOURNAL. It has been supposed impossible to please both the 40 per cent. and the 60 per cent.—a topic of vital importance to the Bart.'s student having little interest for the Harley Street nabob. We shall nevertheless pursue the policy of the extreme centre.



A NEW ROBE FOR RAHERE

By REGINALD M. VICK, O.B.E.

*An Address to the Abernethian Society on
December 1, 1949*

I SHOULD like to preface my address by thanking the President and Officers of this famous Society for the great honour that they have done me by asking me once more to address you. It is an honour which anyone would appreciate but, particularly, a Bart.'s man. On the first occasion that I addressed the Society nearly thirty years ago, I shared the evening with my old chief, Sir D'Arcy Power. At that meeting, he very appropriately dealt with the past and I talked somewhat too optimistically about the present and the future. Sir D'Arcy Power was one of the greatest medical historians of all time. But, probably, very few of you will know that he was one of the most rapid operators—he did his last gastro-jejunostomy at the age of 65, from the first cut to the last stitch in 17 minutes.

In 1919, I gave an address on "Malaria"—a curious subject for a surgeon to choose. But I had just come home from three years in the salubrious climate of Macedonia and what I did not know about the ravages of that dread disease in those days was not worth knowing. Just after the recent upheaval, I gave a talk about the "changing face of Bart.'s" with the idea of acquainting those students of Bart.'s who owing to the war had hardly ever been to their Alma Mater, with some of the history and traditions of the place.

I fear that some people may have formed a wrong impression from the title of my address that I am going to enter the lists in that controversy waged in the pages of the Bart.'s Journal by some very erudite gentlemen as to exactly what robe Rahere did wear. I would not dare to do that. I am speaking symbolically. It is certain that with all the rapid changes that are taking place, Rahere will have to change his robe and I am—with a certain amount of trepidation—taking this opportunity of appealing to you, the students of this generation and of generations to come to see to it that though he may change his robe, he will not lose his soul.

It is one of our gloomy habits in these strange days to keep on saying that everything is changing. And, of course, it is lamentably true. But we must all remember that whatever changes do take place, Bart.'s will go on for ever.

It is not my intention to deal with the far distant history of the Hospital which has been set forth in many a famous volume far better than I could ever hope to put it before you. But I would like, just for a moment, to carry you back to the foundation of the Hospital in 1123—far back in the mists of history. I quote from an oration given by the then Dean of Gloucester at the Inauguration of the Rahere Lodge in 1895.

"Nearly eight centuries ago, Rahere, a Knightly Minstrel of the Court of Henry Beauclerc was lying sick unto death. In a vision of the night, a man of unearthly beauty came and stood by his side and said, 'Rahere, I am Bartholomew, the Apostle of Jesus Christ. Build in my name a holy House of God, in Smithfield by London and lo, I will help thee.' The sickness passed away but the Minstrel of Beauclerc was not disobedient to the Heavenly vision. He devoted his life henceforth to the building of that stately Church we know so well, and close by the Church he placed the Hospital. When these were building, men say how at the hour of Evensong, a strange light from Heaven would play upon the yet unfinished walls and then would flash up into the sky and disappear.

"Ever since those days, the house of prayer and the house for God's suffering poor stood side by side. The Hospital was famous in mediaeval days for gifts of healing—as then, so now. In the stormy days of the Reformation, for a brief season the work of the Church and the Hospital was interrupted. Henry VIIIth restored the Hospital and endowed it. Since then the House of Rahere has grown with the great city in which it stands. A splendid record of noble work belongs to this great House in the relief of sorrow and suffering. It is well known as, perhaps, one of the greatest of our English Hospitals." Except that we might query the word "perhaps" in the last sentence we cannot but admire the stately periods in this, one of many descriptions of our Foundation.

And now, let us for a moment, pass across the centuries to the year of our Lord 1948, at a dinner given by the Treasurer of the Hospital to the medical and nursing staff near the appointed day (July 5th, 1948) the following sentences were printed on the menu

cards: "There are few of us who, at some time or another, have not closed with a sigh the last chapter of a well-worth book. We at Saint Bartholomew's Hospital are about to close the last chapter in the long and glorious history of the most ancient of voluntary Hospitals. That a second book will be written and that it too will be studded with famous names and tell, as in the past, of noble achievements in the service of humanity is poor consolation to those of us, who have cherished the voluntary spirit of mutual helpfulness, for which Bart.'s has been renowned since its Foundation."

I do not know who wrote those words but reading them over and over again helped me to get through an evening, which was a strange mixture of conviviality and depression and has comforted me since. By reciting to you these sentences about the far off days of our Foundation and about the very recent beginning of a new era in the life of our Hospital I hope I have given you some idea of the way my thoughts are running.

I want to tell you something about Bart.'s in the years that have gone—not of the days of long ago but of those years whose history has yet to be written. If I err on the side of personal reminiscence, you must forgive me. After all, to reminisce is one of the few privileges of advancing years. If I am at times rather light-hearted, I feel that after a hard day's work you will be glad to combine entertainment with instruction.

Early Days

When I became a dresser to Sir D'Arcy Power and Mr. Rawling I joined the Light Blue firm, to which, except for two short lapses, I was destined to belong all my time at Bart.'s. I used to ride on a chocolate horse bus from Waterloo to Bart.'s. In 1906, motor buses were unheard of and hansoms still jingled through the streets of London. The surgery—the outpatient department—was in the far corner of what is now known as the Lucas block. The entrance was direct from Smithfield—near the Martyrs' Memorial. I wonder how many of you know where that is and who the Martyrs were. The surgery was far too small. It was always packed with patients and smelt to high Heaven. Those people, once described as the "indignant poor" were very much in evidence.

The firms worked in boxes, which were bounded by nothing more substantial than

heavy screens. Different coloured boards indicated which firm was working in which box. At the end of the morning the boxes were cleared for "minor ops." The East, the West and the South wings housed the cosy wards of the Hospital with their two large open fires. Even the system of communication by tubes and whistles was still used sometimes. You should be reminded of the light-hearted nurse, who poured milk down the tube into the listening ear of the subsequently infuriated Houseman below. History does not relate what disciplinary action was taken.

The Operating Theatres were four in number. Theatre A, which was also one of the main lecture theatres of the medical school. When an operation was to be done the floor was just cleared in its lower part and the operating table and other essentials for the operation brought in. Theatre B at the top of the East wing, then thought to be absolutely up-to-date. Theatres C and D, which were lean-tos, where the million-volt X-ray department now stands. They were temporary structures and functioned for 20 years. And Martha Theatre on the top of the then South wing, which belonged to the gynaecological department and where the Senior Surgeon operated.

The pathological department was housed in two very small laboratories near the Museum. The students fed either outside the Hospital at neighbouring cafés, one of whose staple diet was milk, appropriately called the "nipple," or in a strange room near the Smithfield gate, which was also used as the Inquest Room.

The medical school was very inadequately housed on the Hospital site. The Warden's house and the residential college ran along Little Britain. The Warden's house was 200 years old—very comfortable but rather bothered with mice, who nibbled the gas pipes. In those days, all the main transport of Smithfield market was horse-drawn and came down Little Britain, and the smell had to be smelt to be believed. So much for a brief description of some of the buildings of the Hospital in those days.

The Staff

In 1906, Sir Henry Butlin, the greatest living authority on Carcinoma of the tongue—then a very prevalent disease and since almost disappeared as the result of the more efficient treatment of syphilis—was still a Consulting Surgeon to the Hospital. He

used to ride to the Hospital on a black horse wearing dark grey jodhpurs and his horse had to be walked round and round the Square during his visits. Most of the staff drove to the Hospital in their smart horse carriages.

The Senior Physician was Sir Norman Moore, who wrote the famous two-volume history of Bart's. The Senior Surgeon was Mr. Harrison Cripps. It was always said that he started and owned the Marylebone Electricity Company, which supplied light to the Harley Street area and that he subsequently sold it for a quarter of a million. Both these members of the staff wore beards and, of course, frock coats. It is interesting to recall that, in those days, the physician-accoucheur did not operate within the abdomen. He only dealt with things lower down. The senior surgeon did all the operations for the gynaecological department and now they have a College of their own which they describe so verbosely.

Nursing Staff

Miss Isla Stuart was the Matron. The Sisters of those days were far more terrifying than the Sisters of today. Woe betide the young dresser who allowed one drop of water to fall on the wooden floor of the ward. The probationers did a great deal of domestic work. They wore rather pathetic dark grey uniforms and we all thought that they had a raw deal.

The students and nurses were not supposed to associate with one another, either inside or outside the Hospital. And yet the curious thing was they used to get engaged to one another. When this happened either the student or the nurse had to leave.

Dressers

There were six surgery dressers and six ward dressers to each firm. Medicine was not the crowded profession that it is today. It was not the custom to change from one firm to another. If you belonged to a firm—be its colour light blue, dark blue, green, yellow or pink—your loyalties were to that firm. You might, possibly, condescend to visit another firm on a teaching round, but it was always something of an adventure and one felt that one was being just a bit disloyal. I am not for a moment suggesting that this was a good idea, but it certainly stimulated the team spirit.

We worked very long hours in the surgery. The duties were from a Tuesday to a Friday and Friday to Tuesday and, during those times, one worked at very high pressure.

The patients were so numerous that the dressers often had to take a great deal of responsibility, and many patients were seen only by a dresser. Now and again accidents nearly did happen. As on the famous occasion when a dresser was about to plunge a knife into an aneurysm pulsating through the sternum under the impression that it was some curious form of abscess.

The ward dressers did all the dressings in the wards, and in addition to that, the dresser of a case was responsible for all the instruments and ligatures in an operation. This was called doing "strings." Grand practice for the dresser but sometimes a headache for the surgeon.

The students of those days—apart from the fact that they were of course exclusively male—were much as they are today. A bit tougher, perhaps—I think that they played harder than you do but worked less. Discipline was good—there were a few cases of petty larceny—as then, so now. Chronics—even chronic alcoholics—were much more common than they are today and for obvious reasons.

I do not think that the story of the student who took 30 years to qualify and then was found to have been left £500 a year by an affectionate aunt until he became a doctor, is founded on fact, but it is told at every hospital. I can remember a Nigerian student who took more than 20 years. And, of course, there was the candidate who went up for the Primary F.R.C.S. until well past middle age, when the examining board decided to pass him so that he could go up for the Final before he died. Examiners as a class belonged to a later age group than they do today. One of them was removed from the Court because he would persist in going to sleep during the vivas. The impolite examiner was not unknown and one examiner was knocked down by a candidate. He was a very old man and the candidate was referred for two years.

When I became House Surgeon, I had a most distinguished lot of dressers, though I did not realise it at the time. Ogier Ward, now one of the best known exponents of the genito-urinary art. Major-General Barnsley, now Colonel Commandant of the R.A.M.C. and Bedford Russell, whom you all know. I am delighted to see them here tonight. I know that I enjoyed my time as a H.S. more than any other time in my professional career. For the first time, one felt the thrill of responsibility. Remember, in those days

there were none of those invaluable young men known as Chief Assistants, men ruffling it with their high qualifications and starting to carve their way to fame and fortune. The H.S. had to take the complete responsibility for fetching his chief down to do emergencies. The Senior Surgeon did all the day emergencies and the Assistant Surgeon all the night emergencies. This was a rigid rule, and for the very good reason that there was no one else to do them. I can still recall one's sigh of relief when gas shot out of the peritoneal cavity, when one had summoned the Chief out on a dark and stormy night to operate upon a perforated duodenal ulcer.

Many more acute abdominal cases came to the Hospital in those days than now. It was not uncommon to admit several patients with perforations, of children moribund with peritonitis spreading from an undiagnosed appendicitis. I can remember on more than one occasion operating all night long. This change has, of course, nothing to do with the Hospital itself. It is accounted for by the opening up of other Hospitals in and around London perfectly capable of dealing with surgical emergencies. But, from the point of view of your training, it is a great pity.

And now for a change, may I take you for a short time away from Bart.'s into the world of private practice. I think that going out and about doing surgery in all sorts of places was not only excellent training for a surgeon but very pleasant. The frequent association with Bart.'s men and doctors from other Hospitals was very interesting. In fact, it was then that one began to realise that there were other Hospitals. And it did one good to work in other theatres, where one was not protected by the assistance of skilled people.

And how different it all was from one's ordinary work in Hospital. To take one example. I once remember operating in a private house, a practice which has now almost entirely disappeared, thank Heaven. It was always something of a trial. I remember very vividly operating in a house in Sussex, when it took me and the local doctor and the anaesthetist two hours to get the room ready and then we had to wait another two hours for the husband of the patient, a doctor, and long since dead, to be summoned from the beyond so that he could be present at the operation. This is the one and only time that I have been assisted at an operation by someone who had already "crossed over."

Nursing Homes

One did a great deal of one's work in Nursing Homes in and around London and they were of varying efficiency. Some of them were excellent and some were quite terrible. I knew one Nursing Home where there was only one qualified nurse. Another, where by noon on Christmas Day I and my patient were the only sober people in the Home. One where the Theatre was so small and the Matron so large that she could not come in to the operations. In this Theatre, I recall an amusing incident, when the anaesthetic was being administered by a very cultured George's man, who wriggled about so much that, at last, I had to ask him what was the matter with him. He expressed his apologies but said that he was sitting on the radiator and it was most infernally hot.

I once went to a Nursing Home about 15 miles from London to operate upon a young man with a perforated duodenal ulcer of some hours standing. I found that the Matron who looked after the Theatre had gone out and not left her address, although she knew that there was an operation pending. The Sister left in charge was a hoary old lady, who admitted that she knew nothing whatever about the Theatre. The anaesthetic was appalling and the lighting was a pale blue, which made everybody look as if they were dead before we started. During the operation, the local doctor, who was assisting asked if he could withdraw as he felt ill. I was left entirely alone to sew up the most difficult perforation that I have ever dealt with and do a short circuit before I closed the abdomen. The patient survived and I operated on one of his grandchildren years afterwards. The doctor died some months later and, at the end of the operation, I felt almost dead myself.

It was all excellent practice but it took years off one's life. Fortunately for the surgeons of today this type of Nursing Home has gone, and private wings in Hospitals are taking their place most efficiently. It would be impossible, of course, to do many of the major operations of the present day in the surroundings I have described.

And now something of the surgery of the early days of this century. I think one can say, without fear of contradiction, that anaesthesia was almost in its infancy. In 1906, the Senior Anaesthetist to the Hospital was called the Chloroformist. He administered that dangerous drug with consummate

skill. But what a dangerous drug it was. Patients usually went through a violent excitement stage during induction. Delayed chloroform poisoning claimed its victims. Surgeons used to be kept waiting for periods varying from half an hour to an hour between cases. And often when the patients came into the Theatre, they were not properly under. I can well remember a patient popping his finger into an incision for appendicectomy while it was being made. Then ether came into general use. The Theatres reeked of it and the surgeons went back to their stately homes emanating its fumes. Chest complications were very common indeed.

The full aseptic technique was just beginning to be understood. Charles Barrett Lockwood was one of its most skilled exponents. The surgeons of those days had much shorter tempers than they have today and with very good reason. Lockwood used to have his whole Theatre staff in tears by the end of the afternoon—with the possible exception of his House Surgeon. He was known when he was presented with an amputation knife, an instrument of which he strongly disapproved, to throw it across the Theatre so that it stuck in the door.

One or two more things and I have finished with the past. The Residential College, while I was Warden, was closed temporarily in 1923, and is only now about to be reopened.

Consultations

Medical and surgical consultations at Bart.'s were famed throughout the world. At surgical consultations it was the custom for most of the surgeons to turn up, including the consulting staff, and express their opinions on difficult cases. Sir Henry Butlin was still coming to consultations when I was a student. He was a great believer in drastic surgery in malignant disease and would criticise very trenchantly any surgeon who was shy of extensive operative procedures.

It was worth going to consultations, if only to hear the wonderful clinical opinions of men like Sir Anthony Bowlby. The Senior Surgeon used to speak first. I never thought that this was a good idea as it left the diffident junior surgeons so little to say. In medical consultations, the junior physician spoke first. It was interesting and amusing as well as instructive for the students to see and hear all the surgeons and to realise, often

to their surprise, that very often they did not agree. And of course there was always the hope of a row. And we were not always disappointed. Consultations have long since ceased to be held at the Hospital. It is interesting to know that an attempt has been made at Guy's to start consultations there, and by a Bart.'s man on the staff.

Very soon after 1906, great changes began to take place. The surgery and outpatient department moved to its present building. The pathological block was opened and many people thought that it was too big. The X-ray department opened where it now is—and it has never been big enough. Bart.'s was one of the earliest Hospitals to realise the importance of X-rays and our department was one of the very first to open under Dr. Hugh Walsham.

Later the present Hospital began to take shape. The new surgical block and then the new medical block became the very up-to-date and magnificent buildings that they are today. In their planning, Sir Holburt Waring and Dr. George Graham played a very important part. The Medical College moved to Charterhouse Square and was incontinent and very largely destroyed by fire and bombs before it had been paid for. In its inception and construction, Sir Girling Ball was very largely instrumental but, most unfortunately, he did not live to see the College paid for in 1946, and gradually being rebuilt.

In 1921, the College received its Royal Charter and became an incorporated part of the very young University of London. In April, 1946, an event of major importance took place as on that day women students first entered the precincts of this once monastic institution. One felt that, on that day, some of the long dead members of the staff of Bart.'s must have turned in their graves or rustled their ashes. But they need not have worried. This revolution took place very quietly and the women were received with all the kindness and courtesy characteristic of our Medical College.

In the First World War, I new nothing of Bart.'s as I was away on active service all the time. But we did run a very efficient General Hospital at Wandsworth, and the East wing of the Hospital was given up to soldiers. The staff went rather uncomfortably into uniform. It is recorded that, on one occasion, Dr. Calvert left home in uniform and wearing his top hat, and got quite a long way to Bart.'s before someone

pointed out to him his unusual appearance.

In the recent Armageddon the Mother Hospital, considerably reduced in size, continued under the most appalling difficulties to carry on its functions. In fact, I believe that the only occasion that Bart.'s could not admit patients was when one of the last rockets fell in Farringdon Market—and that was because the casualties were so heavy that the Hospital was full.

The Bart.'s staff took over Hill End and part of Friern Hospital. The one a widely spread out institution near Hill End, and the other an incredible building in New Southgate. In those two places, Bart.'s men worked and lived and tried with difficulty to carry on the great traditions of our Alma Mater. At Friern Hospital, at one time better known as Colney Hatch, the staff housemen and some of the students lived in. And believe me or not, we were quite reasonably happy. Most certainly some very good surgery was done. Our patients were ordinary civilians, air raid casualties, soldiers of all races, and in the dim and dark wards behind us dwelt more than two thousand of the mentally deranged. We almost forgot that they were there.

I often wondered how the mental patients would behave if a bomb dropped on the Hospital. And when that did happen, we found that they behaved rather better than normal people.

And now to deal with some of the advances that have taken place. Anaesthesia has advanced by leaps and bounds. Now you just lie luxuriously on your stretcher in the anaesthetic room, feel the gentle prick of a needle in your arm and you know no more. Curare produces a relaxation hitherto unknown, but, as happens with all new discoveries and advances, there are martyrs. We have all heard of X-ray martyrs—their misfortunes were ventilated in the Press. But what about the martyrs to radium and deep X-rays with their overdoses and their terrible burns, now, thank Heaven, a thing of the past. What about the patients who were given Avertin in its early days and had to have artificial respiration for hours and sometimes never breathed again. Of course, anaesthesia still has its risks today. One has only to see a real pukka Pentothal spasm to realise that.

With the advance of anaesthesia, surgery advanced step by step. So now we have almost perfect anaesthesia, perfect asepsis and, with the help of penicillin and the sul-

phonamides to combat infection in operations like abdomino-perineal resection of the rectum and cerebral operations, there is nothing that a modern surgeon dare not tackle. Think of leukotomy, for instance. I know of one gravely deranged patient, who had a leukotomy performed and later escaped from the Hospital which guarded him, stole a car and was found five days later living at a luxury hotel near Guildford. And no one had noticed any difference between him and any of the other guests.

One can say with truth that surgery has advanced more in the last fifty years than in any period in history and there would appear to be no limits to what the skill of surgeons may deal with in the future. How fortunate indeed are the young surgeons of the present day. But we must not forget the grand old men of the past, who showed us how to do major surgery under the most appalling difficulties. They were pioneers indeed.

I have given you some sort of picture of the past, indicated those changes which have brought us to the present and hinted at what may happen in the future. I have told you something of what Bart.'s was like nearly fifty years ago and of the changes, which have made it the magnificent Hospital it is today. I have mentioned a few of the famous Bart.'s men of the past. And it would be natural to ask "Haven't we got any famous men today?" Of course we have, but it would be rather invidious to give you a list of them. (At this point, the speaker gave the names of some six present day Bart.'s men, who could justly be described as famous—each name was received with applause.) Modesty forbids me from elaborating this list. I would rather remind you of all those other members of the Bart.'s staff, who are doing magnificent work in the relief of suffering, or research into the origin and treatment of disease. Or, even carrying out the less dramatic functions of teaching Bart.'s students to be good doctors. There are plenty of them and there is nothing the matter with the spirit of the old place.

We have always been accused of being reactionary—horrid word—but, to my mind, Bart.'s is the most go-ahead Hospital I know. What we do is just to wait a little to see whether a treatment is any good or not. And when it turns out to be a winner, we back it more quickly than anyone else.

I expect that you will all be glad to hear that I have nearly finished. And, in the phrase of which I have been so fond in all

my teaching life, "If you remember nothing else, do please remember what I am going to say to you now."

I would now tell you what I consider the outstanding difference between Bart's and any other institution that I know. It is that wonderful spirit of cheerful helpfulness and earnest co-operation which I have never known lacking during all the years that I have worked here. I have never (and I use this dangerous word without the slightest hesitation) known a patient unkindly treated at Bart's. I have always found that patients who have been to Bart's never want to go to any other Hospital. I have even known as I have already told you, the spirit of Bart's carried into another Hospital.

Please do not think that I am telling the tale or that I am unduly biased. You will be able to test the truth of what I say in the years to come. Wherever Bart's men get together, they help each other—sometimes rather to the annoyance of the alumni of other schools. And that wonderful spirit exists today unchanged as it has throughout the ages. We have now passed into another era—into a future that many people dread and that no one looks forward to without

some qualms. Far be it from me to digress into politics, that strange and twisted game, where even the best people lose their heads and talk without thinking. There is, however, unfortunately no doubt that the relation between doctor and patient has subtly changed since the National Health Service started. That change has not yet reached Bart's and pray God it never will.

And now I want to leave a final thought in your minds. I want to appeal to the present generation of Bart's men and women and to generations yet unborn; in spite of the National Health Service, in spite of the new relationship between doctor and patient, in spite of the soul destroying flood of rules and regulations, forms and certificates, in fact, in spite of everything—to keep at full strength that vital living spirit, which shows patience in all difficulties, gentle consideration even under exasperation, and radiates kindness and comfort to all around you. Thus and thus only will the glorious traditions of this beloved Hospital be preserved. Thus and thus only, will old Rahere don his New Robe with a glad heart and carry on the good work throughout the centuries to come.

PLUS CA CHANGE . . .



Photo: H. Charles, Bart's Photographic Society.

IMPROMPTU IN EXTREMIS

(A dramatic episode in 13 acts)

ACT I

(The scene is the Accidents Box at an indeterminate hour—such windows as exist being impermeable to light. The bareness of the white tiles is relieved only by their occasional absence. Up-stage L. are posters reading, "A Shadow on Health; trap the germs by using your handkerchief," and "Mist. Expect. The great Rejuvenator—refuse imitations. No responsibility can be accepted in actions brought by the L.P.T.B." Nothing can be heard save the soft murmur of generalised incompetence. A houseman is seated at a desk [centre] and the Minor Chorus is lined up down R.)

A dresser enters R. He wears the ceremonial uniform of the Household Cavalry which is partially concealed by a short white coat.

HOUSEMAN: Next time you send your demob. suit to the cleaners why not take a week in bed?

DRESSER: There is an Eastern Professor of Egyptology without. I think he has *(in a whisper)* a euphemism of the aorta.

CHORUS: If we seem a bit agnostic
In these matters diagnostic,
It isn't due to kindly tact
But to the very awkward fact
That if we told the patient all
He would certainly recall,
What we told him he had got
When he finds that he has not.

HOUSEMAN: Ah! The great imitator! What are his symptoms?

DRESSER: None.

HOUSEMAN: Let me put the question in another way. Why is he here?

DRESSER: Well, he thinks he ought to have some in view of the gravity of his condition.

(Enter the Professor, R. He is a small, clean-shaven man and is naked except for an overcoat, hat, muffler and a pair of corduroys. He rushes to confront the Houseman.)

CHORUS: See, he's unsteady on his fate.
Can it be the spirochete?

PROFESSOR: 10¹⁰ effusive and humble greetings, your exigency. I can conceive no greater ecstasy than to eviscerate myself in your presence.

CHORUS: This man is plainly Oriental,
His language very ornamental.
Its intricacies we haven't mastered.

He's certainly a queer old person.

PROFESSOR: *(Withdrawing an articulated shooting-stick from the interstices of his beard and perching himself on it).* I would in fact grovel were it not for the streptococcal contaminants of your floor-dust.

CHORUS: Haemo-lysis, haemo-lysis,
Stick 'em on blood-agar slysis.

HOUSEMAN: *(Thrusting a bell-piece into the patient's bosom).* Ah! Bronchophony.

DRESSER: Er—quite.

HOUSEMAN: From the Latin of course—

Broncho—"I bellow"—phony, "down a tin tube."

(A very fresh bespectacled probationer enters R. carrying four mattresses and having a variety of clinical impedimenta hanging about her person. She is enamoured of the Houseman, whom she seeks to impress with quotations and original verse acceptable to an Oxford graduate.)

HOUSEMAN: Busy tonight, ducks?

NURSE: But I keep going.

"Will-power is the decision of character, the outcome of mental stability, the very quintessence of all the virtues and only to be perfected after many a weary struggle and many a bitter experience" *(apologetically)* er—as it were *(exit)*.

PROFESSOR: Now where's that from?

HOUSEMAN: Cheltenham L.C. *(rising)*, now Sir, if you will kindly assume the lithotomy position I think I can put my finger on the trouble.

CHORUS: Look how near his knees his nosis
This will clinch the diagnosis.

HOUSEMAN: Come, Sir, if you persist in your attitude I shall have no other course open to me than to call in a surgical colleague.

(The professor leaps to his feet alarmed and extracts a small silver hunting trumpet hurriedly from his shopping bag. He blows a piercing note. Immediately there is a trampling of many feet off-stage and a rumble of distant cannon: the stained glass French windows [centre] burst open and a chorus of twenty tabetics enters. They form up three deep and are about to chant but the lights are suddenly extinguished and the curtain falls to the sound of stumbling bodies.)

END OF ACT I

E.A.B.

PRINCIPLES IN THE TREATMENT OF ATHLETIC INJURIES

By R. SALISBURY WOODS

It is a great honour to be invited to contribute to the St. Bartholomew's Hospital Journal. In justification, I can only plead the inadequately extenuating circumstance that, at the beginning of World War I, when St. George's Hospital lacked a complete XV, I enjoyed the privilege of playing in a number of matches for Bart.'s!

This article is based on experience derived in the main from the undergraduate section of a practice in the University town of Cambridge, extending over 25 years, and comprising many thousands of cases. In such an able-bodied and highly competitive (sporting) community, the features essential to the treatment of any injury are rapid restoration of function, and fitness to withstand fresh stresses.

Moreover, sport is so exacting in its demand for swift return to the arena that it is of interest first to see how the injured fared about 80 years ago. Consulting Erichsen (1), a standard authority in 1869, we are advised to treat a badly sprained ankle with "rest and perfect immobility . . . leeches . . . and when subsided . . . supported with . . . starched bandage or leather splints. Later kneaded until . . . strength and mobility are restored. This very commonly does not occur in sprains of the knee and ankle for *many weeks*"!

Of Colles' Fracture (treated in flexion, and bandaged to a piece of padded wood), Erichsen wrote: "It will be *at least three months* before stiffness of the hand and wrist are so far diminished, even by the use of friction and douches, for the patient to use his hand"!

Fortunately modern progress is such that, about from 1930 onwards, Lorenz Böhler, of Vienna, after reduction under local anaesthesia, treated these cases by fixation in a *non-padded* plaster splint, and between flexion and extension, followed by immediate full active function of the digits, and the elbow and shoulder joints. He stated in 1933 that "a seamstress, aged 56, resumed her work *three days* after reduction of a Colles' fracture with extensive displacement . . . Writing is also possible after a few days."

It is proposed to discuss types of injury in evolutionary order of the improvement effected in their respective treatment.

Shortening Sick Wastage

Initially inspired by the early work of Frank Romer, and after many years of constant experience at home, and on tours abroad amongst every type of university sportsman and woman student engaged in athletics, rugger, soccer, hockey, rowing, cricket, tennis, boxing, ice-hockey, hunting, steeplechasing, etc., *one principle in treatment* has been found to apply to almost every injury, except those of the head, viz. (in so far as it may be possible) *to support the injured part and to encourage immediate natural use*. To this may be added a warning against premature rubbing, massage, or manipulation of sprains and severe bruises, which can only defeat the processes of healing, result in further extravasation, tension and pain, and lead to lengthened incapacity.

Function v. Rest and Physiotherapy

Practising in Cambridge, and faced with the necessity of restoring the injured athlete (often a probable or actual "Blue" or "International") as soon as possible to an important series of contests, it was found necessary as long ago as 1923 to break away from traditional doctrine, a 30-year-old legacy of Hilton's teaching, which created a bias in favour of rest for all painful injuries. (This promotes the formation of articular and peri-articular adhesions, and of inelastic fibrous tissue in damaged muscles. Incidentally, it has made the fortune of the bonesetter.)

Hospitals, in their overburdened teaching curriculum, have had little time to spend on ordinary sprains, strains and bruises, and old methods have been perpetuated in text-books. Treatment of fractures, though ranking far higher in importance, also lagged in progress until Böhler's work established the advantages of early function.

Instead, therefore, of following the orthodox "masterly inactivity" (made palatable by massage as evidence of something attempted), a sprained ankle or a "pooped" thigh was immediately supported with adhesive strapping, and the patient made to bear weight and to walk at once. This was facilitated by a wealth of athletic material, urgently anxious to co-operate. Rugger players were thereby enabled to train in a few days and to play in a week—a revolu-

tionary advance on the teaching and results current at that time (1923). (The writer himself, after severely spraining his ankle while still a competing athlete, was able very successfully to make trial of this method for expediting his own return to the arena.) Romer extended the idea to treatment of fractures of the clavicle and other injuries.

Others have investigated the pathology and have urged the use of physiotherapy and active exercises in athletic injuries, whereby adhesions may be prevented and the empirical bonesetter deprived of his prey.

Injuries of Joints

*I. Sprain (mainly extra-articular).—*Taking the sprained ankle as the commonest example, the benefits of immediate firm support and natural function are seen to be various and complementary:

(a) *Local.*—(i) Damaged ligaments are relieved of stress.

(ii) Extra-articular hæmorrhage is limited by immediate firm pressure. There is therefore less to be absorbed.

(iii) Increasingly active movements, by alternately pressing and relaxing under the strapping, furnish natural (and, incidentally, *free*) massage, which enormously hastens reduction of swelling.

(iv) Where tendon sheaths are involved in the damage, early movement prevents adhesions.

(v) Disuse-atrophy of muscles acting upon the injured joint is prevented, the blood supply and tone being maintained.

(vi) Even where there is a synovial effusion these severe cases benefit most by this treatment.

(vii) Massage is largely eliminated, natural function taking its place from the time of receipt of the injury; it is, however, of advantage in hastening the late stages of recovery (loosening-up, etc.).

(b) *General.*—(i) The whole body is enabled to keep fit and more or less in training, instead of having to start from zero after a period of couch and crutches.

(ii) Morale is maintained by a consciousness of activity and of rapid progress, an important factor in the highly strung athlete or player.

*II. Sprain (with Synovial Effusion).—*Although strapping injured ankles has gradually become recognised treatment, it is probably true to say that a peculiar reverence is still usually accorded to injuries of the knee-joint with synovial effusion. Even

today the simple sprain (or "water-on-the-knee") of so many games players is liable to be rested, swathed in Scotts' ointment, banded and, of course, "massaged," with or without "electricity." But, as far back as 1932, necessity emboldened a trial of adequate support and immediate gentle ambulatory treatment in a 'Varsity wing three-quarter. This man would otherwise have been too late for a Trial which led to his "Blue" 14 days later, and no recurrence. After that he played several seasons for Scotland with no relapse. The technique then devised for strapping the knee-joint has been uniformly successful with all subsequent cases in shortening sick-wastage from this very common cause of being "crooked."

The detail has been published, but is rather outside the scope of this paper. It is sufficient to show that the injured knee-joint, for many years regarded as sacrosanct, may be brought into line with the ambulatory ankle. In this case, however, early massage and Faradism are indicated for the reflex atony of the quadriceps femoris m., always associated with severe injuries of the knee-joint, and generally leading to muscular atrophy, particularly of the vastus medialis muscle.

III. Hemarthrosis.—Even when there has been a copious hæmorrhage into the knee-joint, as may follow a kick from a horse or from a violent twist, the same principles apply. Under rigidly sterile precautions, the effusion is drained off after 24 hours by a stab puncture, followed by suture. Firm strapping pressure is applied over a dressing, followed by walking in two to four days. Recurrent oozing is then unlikely, the case is treated as for synovial effusion, and recovery is similarly speeded up.

IV. Traumatic Dislocations.—A dislocation inevitably injures all the component soft structures of a joint severely, and considerable effusion of blood is always present, infiltrating the whole area involved.

Reduction is, of course, the first consideration, after which, current teaching enjoins rest and passive movements after about a week. Thus we read in Romanis and Mitchener: "Once effusion is subsiding, passive, leading to active, movements may be commenced, being controlled by the production of any pain or spasm. This will be an average from five to ten days' . . . Lastly, adhesions may form which will require breaking down . . ."

It is the purpose of this paper to show that

active movements may be instituted at once, and that adhesions should never be *allowed* to form.

In dislocations of the elbow-joint particular care was exercised, and it was recommended (Rose and Carless) that "the joint should be kept flexed at a right-angle for at least two to three weeks lest traumatic myositis should supervene"; and, again (Romanis and Mitchener) "Passive movements may be started after five days, and active movements after fourteen. The sling is discarded in three weeks, but no heavy work for six." This customary sentence would in effect debar a player from Rugger for the rest of a given season!

Now this problem of expediency versus orthodoxy, in the elbow-joint, presented itself in the case of a patient who, playing for Cambridge as a scrum-half, had every hope of gaining his "Blue" in his very last year, and who was willing to take any risk for his last chance:—

"O.B.," November 12, 1934. Complete backward dislocation of right elbow. Tackled with a Ju-jitsu lock. Morphine, gr. $\frac{1}{4}$, statim. Reduction under "G. and O." half an hour later. One and three-quarter inch swelling appeared in both the arm and forearm.

After-treatment: In bed suffering from shock and great pain 48 hours. Then left nursing home and began walking exercise and active movements of right wrist and shoulder joints. Massage instituted twice daily for swelling, and *active* movements encouraged as far as possible, but *no passive* movements allowed. Radiant heat and Faradism also given to the muscles.

Fourth day: Patient was tried with handling a rugger ball, and made to use it, swinging both arms in unison, thereby regaining the tactile skill of his fingers, and using the whole limb, including the elbow-joint. This was gradually increased.

Seventh day: Running and passing with the other players on the University ground. All swelling rapidly disappeared under this régime: he was put on exercises such as "press-ups," handing-off against a solid wall, and he played squash twice daily.

Eighteenth day: He engaged in Rugger practice, tackling without ill-effects.

Nineteenth day: Played for the University, and sufficiently well to be awarded his Blue, as completely reliable.

Bearing in mind the precision demanded

of a keystone scrum-half in handling and passing out the ball, I do not know of any player whose courage and persistence have been rewarded in so short a time by successful trial in a rough-and-tumble game. He suffered *no* permanent disability.

It is seen, therefore, that the general principles already advocated in this paper are also applicable to dislocations, except that in this instance recurrence in an elbow-joint being impossible during treatment, the factor of very firm support does not arise where stability is already ensured.

Injuries of Muscles

A typical example is the "pooped" thigh, commonly caused by a violent blow, usually from the momentum of a boot, knee or elbow, at "Rugger" or "Soccer," and equally well-known to American footballers as "Charley Horse." It results from localised crushing and transverse snapping of quadriceps muscle fibres struck in a state of contraction. Profuse capillary oozing may follow, with much swelling, tension, pain and disability.

If these cases are made to lie up, hæmorrhage will proceed until checked by the increasing pressure it causes, and the above sequelæ will all be intensified. I once saw a steeplechase rider who had been kept lying-up for *six weeks*, by which time the quadriceps muscle presented much scar tissue and brawniness, while the knee-joint was limited to 30° flexion by (extra-articular) adhesions!

The best treatment is firm support of the whole of the thigh at once by strips of interlocking strapping, starting from below. The patient is then encouraged to walk gently, and increasingly to use the injured muscle. As in sprained ankle, the principle of this method is to prevent further hæmorrhage, to hasten absorption by natural massage, to prevent disuse-atrophy and to enable the whole body to remain fit.

Fracture of Bones

While the above advantages thus became available for athletes with injuries of joints and muscles, a fracture was still a fracture, i.e. a cause of prolonged disability, until sound bony union was complete, muscular wasting cured, and skilled co-ordination re-established.

In major fractures of the lower limb weight-bearing was not attempted until after eight to twelve weeks; the atrophied muscles required at least a further three months to regain their full power, and neighbouring joints were often impaired for life. Working

for various insurance companies, I still frequently see such end-results which are entirely avoidable.

The erroneous principles responsible for this lamentable state of affairs were mainly: (1) Incomplete reduction of the fragments; (2) failure to retain them in accurate alignment until union was sound, i.e. inadequate support; (3) abolition of active natural function for a period of weeks or months; (4) *passive* movements, causing mobility of fractured surfaces.

Böhler's Methods — mainly Non-operative

In the last 15 years, the genius of Lorenz Böhler, of Vienna, has revolutionised the whole treatment of fractures. For instance, those with a broken leg may now walk without crutches on the very day of the injury, and a seamstress with a severe Colles' fracture of the wrist may resume her work in three days. (v.s.)

The cardinal features are very important:

(1) Local or regional anaesthesia for nearly all cases (simpler, lasts longer, better relaxation, single-handed reduction).

(2) Immediate and accurate reduction of the displaced bone ends under X-ray control.

(3) Absolute fixation of the replaced fragments until union has occurred; usually by a non-padded plaster-of-paris splint ("Cellona" P.O.P. bandages, in England).

(4) Minimal immobilisation of limb while controlling fracture, allowing maximal freedom and use.

(5) Immediate functional restoration of movements, including (in the lower limb) weight-bearing where possible, while the necessary fixation is maintained.

(6) No open operation, even in closed fractures, except where there is separation of the fragments, e.g. of the olecranon or patella, or in some fractures involving joints in which the joint surface is twisted, e.g. upper and lower ends of humerus, in upper end of radius, in sub-capital intra-articular fractures of neck of the femur (and, it may be added, in cleft fractures of the upper end of the tibia).

Naturally, technical skill and experience are necessary in fitting plaster casts, especially where there is much swelling, and two stages may be necessary.

Ordinary Splints now Obsolete

These really basic requirements, as preached by Böhler, of accurate reduction, fixation and function, were not satisfied by most of the splints whose employment was

a standard routine in hospitals until recent years.

Nowadays fractures of the tibia and fibula, fairly common in those who play rugby, soccer, or hockey, should be accurately reduced under local anaesthesia (*by screw traction if necessary*), and the position accurately maintained by a simple, non-padded plaster-of-paris splint of "Cellona" bandages, which sets immediately, fitted with a "Duralumin" walking stirrup. In simple, and particularly transverse, fractures, walking may be commenced at once, and the patient should be able to walk up to a mile within the first week. Even in oblique and multiple fractures, where telescoping would formerly have been inevitable, ambulatory treatment is, nevertheless, rendered possible by transfixion-fixation of the fractured tibia above and below the fractures, by means of stout transverse steel pins, whose projecting ends are embedded in the irregular cylinder of plaster.

The saving in stiff joints, hospitalisation and expense is nothing short of dramatic, and the massage of natural function replaces the dreary and expensive daily ritual of months of "physiotherapy," when patients languished on beds, couches and crutches. If reduction has been satisfactory, there will be full range of movement two weeks after removal of the plaster. *The only massage the patients need is the massage of function.*

An actual case may help to illustrate the foregoing abstract principles:—

G.H.B., a Caius undergraduate, on October 23, 1936, was playing hockey when, tripped by a stick, he fell, with severely injured left leg. Half an hour later, distortion, tremendous swelling over lower half of tibia, ankle inverted, obvious crepitation, X-ray showed marked displacement. Under local anaesthesia fractures reduced and limb securely "put up" in "Cellona" cast from sole to mid-thigh. Patient spent a comfortable night.

October 24: Radiography showed multiple fractures, and though position obviously greatly improved, some angulation of tibia laterally. Even fibula, though intact, was bent outwards. Therefore decided to effect further improvement and minimise sick wastage by operation remote from the fractures.

October 25: Plaster cast removed under anaesthesia, leg cleaned up and sterilised. Kirschner wire drilled through os calcis and

screwed taut in Max Page stirrup. Connected to screw-traction apparatus with spring balance, knee being flexed over padded bar in Böhler extension frame. Forty-five pound pull exerted, and fragments manipulated into accurate alignment. Tension then maintained while two stout transfixion pins were bored through tibia, one just above ankle-joint, the other through tuberosity of tibia, and left with their ends projecting. The limb then encased in mid-thigh "Cellona" cast by usual technique, leaving toes free, embedding ends of pins, and surrounding the Kirschner wire in a rigid, irregular cylinder. Wire then withdrawn, releasing traction, and punctures sealed. Projecting spikes blunted with plaster knobs and walking stirrup applied. Radiography showed position perfect.

October 26: Patient very well, toes warm, no oedema. Twenty hours after operation encouraged to walk with sticks about 10 yards and back again. No discomfort (and no crutches).

October 27 to 30: Walked whenever he felt like it, and has walked up and down stairs without help.

October 31: Six days after operation, discharged and returned to rooms in College.

November 12: Has dined nightly in Hall, attended lectures, and walked about the town. Has had no pain. *Never used a crutch.* Skiagrams show perfect alignment of tibia.

This man reported from W. Africa in 1946, and it was impossible to distinguish the fractured leg from its fellow.

Another graphic early instance may be mentioned of a young woman, Mrs. M., *at. 28*, weighing 12 stone, who broke her leg while skating in 1936.

Six spiral oblique fragments middle third of tibia, one piercing skin; fibula also fractured in upper third. Similar principles in treatment applied; walked without crutches in two days; left nursing home in six.

Cast and pins are usually removed in about eight weeks, and an ordinary non-padded cast applied for a further fortnight, during which patients can easily walk two or three miles a day. If an "Elastoplast" puttee is then applied from the toes to the lower thigh there is practically none of the prolonged oedema which was formerly so troublesome in fractured limbs, necessitating further weeks of massage.

Throughout treatment the patient is made to do all manner of general "physical jerks,"

rowing exercises, etc., to contract the quadriceps femoris m. and to move the toes.

It may fairly be claimed that Böhler's principles save such cases about eight to ten weeks off their legs, "an incalculable degree of disuse-atrophy of the muscles, prolonged sick wastage and tedious training back to proper strength, and a staggering bill for months of massage which . . . function obviates almost entirely."

Indeed, it would be impossible to achieve a perfect result in badly comminuted cases, with so little interference with the patient's routine, except by using Böhler's technique of screw-traction and absolute retention of the accurately reduced fragments. An athlete can return to his games with no disability, after the shortest possible absence.

Ununited Fractures

Formerly ascribed to constitutional and other causes, these are generally found to be due to *faulty position* of the fragments with interposition of soft parts. Ununited fracture, or pseudarthrosis, should not occur if sound general principles are applied.

Concussion of the Brain

This injury, as sustained by those taking part in sport, is mainly encountered in Rugby football, hunting, steeplechasing, boxing and motor-cycling.

Concussion is *probably the most neglected of all sports injuries*, for while, as has been demonstrated, joints, muscles and bones are unduly rested, the damaged brain is not rested nearly long enough.

As soon as a man regains consciousness at rugby or boxing, for instance, he is encouraged by his supporters to play on or to box on, and often functions fairly successfully as a pure automaton for the rest of the game or bout.

In my experience, however, it is of the greatest importance not only that such men should not be allowed to return to the field or ring, but that they should be kept quietly in bed until the pulse, blood pressure (charted) and nervous reflexes become stabilised at the normal again. This always outlasts the symptoms of headache, etc., generally taking at least a week, and possibly three weeks. Concentration upon work for examinations is best avoided for about four to five weeks, and in severe cases for three months.

If this caution is not observed (as anyone with experience of head injuries knows), these cases may suffer later on from intract-

able headaches, impaired memory, and other after-effects; and at a late stage it is very difficult to do much for them.

Conclusion

Admittedly, major fracture work demands skill and special experience but, in the main, the theme of this necessarily condensed article is *widely applicable* (to bones, joints and muscles) and *easy of adoption*.

If then, these general principles of adequate support and immediate natural function

(however modified) are accepted in treatment, whether of sprained joints, of torn muscles, or of fractured bones, it is quite certain that a great deal of unnecessary pain, sick wastage and lasting disability will be eliminated from our practice; and many an athlete's jeopardised ambitions will be still realised by rapid recovery, in spite of untimely injuries.

No athlete of today should be submitted to delayed or obsolete treatment, nor to the pain and the waste of health, time, enjoyment and money which it entails.

THE STUDENTS' UNION ANNUAL BALL

FOR the second year in succession the Dorchester Hotel was the scene of the Students' Union Annual Ball, and although the night of January 20 was very cold it did not deter Bart.'s men and their partners from making the occasion a gay and festive one.

Dancing commenced at 8.30 p.m., to the music of Bill Savill and his band and the ballroom soon filled as the 500 guests gradually assembled.

Many of the ladies had chosen the currently fashionable strapless evening gowns—a choice entirely justified by the charming results obtained.

Professor O. J. E. Cave, who had swapped his usual white coat with the turned-up collar, for white tie and tails, came with his wife and daughter, Veronica, and Dr. Jamieson, with other members of the Pre-Clinical Staff, formed another merry party.

Most of the Hospital Departments were well represented. Professor Garrod was present with his wife and two sons, and several other members of the Pathology staff were there. Dr. Strauss, President of the Students' Union, presided genially over a large and hilarious party. Mr. Badenoch had joined forces for the evening with Dr. J. G. Williams, Dr. Kemp-Harper and Dr. Levitt.

Members of the Dental Dept. were also present—Mr. Hankey and Mr. Schofield acquitting themselves creditably on the dance floor.

Dr. Cates, in great form, was one of a large party composed mainly of Chief Assistants.

Students from both sides turned up in quite large numbers, Mr. B. Hick being "father" to a large party of "Clinicals."

Excellent refreshments were provided and the occasional high note of a champagne cork popping became more frequent as the even-

ing wore on—an indication of the rise in alcohol consumption and consequently the spirits of the guests.

At midnight Mr. Bryan Bailey introduced the cabaret, which was produced by Mr. Jack Rodney. It was unfortunate that some of the items were not really in keeping with the merry mood of the audience, but Mr. Patrick Corgill, who had travelled from Windsor, where he is appearing at the Theatre Royal, certainly seemed to capture the spirit of the party and greatly amused Mr. Tubbs whose table was near the dance floor. Others taking part in the cabaret were Miss Angela Oswald, Miss Pamela Marmont (appearing in "Oklahoma"), Miss Mary Loraine, Miss Mary Kimber and Mr. Jack Rodney (who are appearing in "On Monday Next.")

The cabaret over, dancing was resumed with a succession of quick-steps and waltzes, not forgetting the South American influence of rumbas and sambas. Mr. Capp's "execution" of the samba was a joy to behold.

The "Harry Lime Theme" was one which recurred more than once during the evening (coloured lights playing on the dancers during some of the numbers lent an air of enchantment and unreality to the scene).

At 2 a.m. the Last Waltz was played, and after "The King" the ballroom slowly emptied.

It was a most enjoyable evening and our thanks are due to Mr. John Pittman (Chairman of the Ball), Mr. Peter Mathews, who worked hard as Senior Secretary of the Ball Committee, and the other members of the Committee who helped to make the occasion such a great success.

H. B. (Miss)

PITFALLS IN GASTRO-ENTEROLOGICAL DIAGNOSIS

By INDIRA

I AM a general practitioner. Mrs. Brown called in the other morning. She is one of those women about whom you notice nothing except the feathers that sometimes sprout out of her hats. She has the sort of face that makes you write "psychosomatic case" on the blotting paper in front of you—a face psychologists like to ask a lot of questions of, and draw out the sub-conscious under light anaesthesia. I recall the last time she came to me complaining of a stomach-ache. I diagnosed gastritis and gave her a bottle of Methylene Blue, which she brought back two days later telling me that it put her "off colour" and that it did her stomach no good. How ignorant patients can be! It was not unexpected that the drug gave her a bluish tint.

I reassured her only to find that the pain had now spread to her back. A part of my silent cortical area is reserved for problems in differential diagnosis. I tried hard to work out the causes of backache. It is difficult to remember. My theory is that repeated abuse of the cortex leads to the formation of adhesions and one could not very well try and manipulate the head to try and free the brain within, without offending psychosurgeons whose job it really is. A bit of fibrositis perhaps . . . indigestion . . . or just reading in bed? Intrathoracic new growths and Carcinoma of the Pancreas suggested themselves to me but I hastily dismissed these surgical thoughts as being unworthy of a good physician. I prescribed her an orthopaedic corset, which doesn't look too bad but must be a bit stiff to wear, and asked her to come back in a couple of months.

She returned the other morning and said she thought she had a spanner in her works. I sent her immediately to a psychiatrist. Although he tried different techniques to draw out her subconscious the only intelligible comment she made was "I think I have a spanner in my works." He tried electrical convulsions therapy and put her through a course of insulin therapy and took five consecutive electro-encephalograms. This told him nothing further and so he referred her to the psychosurgeons. They warned her that prefrontal leucotomy was still in the experimental stage and told her

not to expect too much, and then went on to sever all her cortical tracts. I saw her again five weeks later. She came up to my desk and held an open ink bottle upside down. The patterns which the ink made on the carpet captured my interest and we both watched them for a while. Suddenly I was horrified to find my pin-stripe trousers stained but I smiled encouragingly and asked her (she is my panel patient you see) how she felt after her operation. She replied that she thought she had a spanner in her works.

I knew a house surgeon at my old hospital . . . a very self-complacent sort of chap who thought he could diagnose anything (he got a house job and I didn't). I thought I would put an end to his pride by sending Mrs. Brown to him. After rescuing some paper which had not been completely submerged in ink, I wrote as follows:

Dear Jim,

Re Mrs. Brown.

This lady complains of a "spanner in her works." She has no cortical lesions because she has had everything psychiatrists and psychosurgeons could offer. I fear that their efforts have not been eminently successful, and I would, therefore, be grateful to you if you could admit her for complete investigation.

I hope you are well on the way to becoming a senior surgeon on the firm. The number of forms that I have to fill in in general practice is giving me writer's cramp.

Yours, etc.,

Indira

Mrs. Brown gave my letter to the house surgeon, who happened to be on duty at the casualty department. He put it in his pocket, beckoned a dresser, instructed him to take a history and then went over to have some coffee. The dresser was only just getting used to holding a surgical appointment. What's more important is the fact that he had been spending all his savings on making long journeys to a far-away hospital pursuing a course of lecture-demonstrations on psychological medicine. He didn't go there merely to get signed up, but was genuinely interested. Not having seen my letter he asked her a few questions and put down "cortical lesion." The H.S. came

back, pulled out the letter and read it and said to himself "Ah, a case from my old friend in general practice! Thinks she will fix me by sending a difficult case. I will have her admitted right away for investigations." Mrs. Brown was admitted into a large ward and they did her ESR, MCD, MCH, MCV, CSU, CI, Bleeding time, Marrow biopsy, Differential count, Icterus Index, Diastase index, Prothrombin time, Lumbar puncture, and a Uric acid estimation, and the nursing staff faithfully entered the temperature, fluid intake and output on her chart and did all the other things they do in large wards of well-known hospitals. The H.S. went through all this in the evening and got into a panic saying to himself, "Heavens! Whatever will my chief tell me if I don't get an ECG taken and a total cholesterol done, and the sputum examined." So he drew out a pile of pathological investigation cards and filled them hurriedly. There was a phone call put through to the ward that evening but the things the pathologist said are better left unmentioned. To make sure he would become a chief surgeon one day and ride to the hospital in a big shining car the H.S. did a hurried examination of the fundi and a proctoscopy. "No abdominal examination," he said to himself, smiling confidently, "is complete without a P.R.!"

The chief was very busy the next morning. He spoke to some new dressers of the importance of taking a detailed case history and making a thorough physical examination, and left because he had an important lecture to give. However, he did manage to snatch a hurried look at the vast pile of reports which had gathered towards the distal end of Mrs. Brown's bed and expressed regret that no X-rays nor Barium meals had been done. So the next few days were spent in getting Mrs. Brown to swallow Barium but all the radiologist could find was a diffuse shadow in the subcostal region and could make nothing of it. So he told the technician to try and keep her head out of the way of the X-ray plates. This didn't help the surgeons one way or the other and so they decided to perform an exploratory laparotomy.

The lights shone in the theatre, the house surgeon used his elbows to turn off the taps and said a few things to impress the dressers. The chief said he would have his sandwiches later and the theatre sister blushed. Soon

after this he was making a paramedian incision. The dresser beamed with delight because he had been allowed to hold some retractors, and the H.S. felt that they were going to hit on something important and was trying to work out a stratagem to persuade his chief to let him write up the case in the literature. He drew his head out of the way of his chief's headmirror, hit the back of his head against the theatre light, had slight concussion and leaned heavily on the "pro." She blushed. The chief did an appendicectomy, followed it up with a brilliant cholecystectomy and then removed several bits of viscera which he felt might be precancerous. While manipulating the stomach with a gloved hand he felt something. He looked at the anaesthetist. The anaesthetist looked at his "Times" crossword. The chief made some scathing remarks about anaesthetists in general. This annoyed the anaesthetist who pumped the sphygmomanometer vigorously and took a peep under the cloth to find, much to his embarrassment, Mrs. Brown giggling stupidly. He turned on a few more taps and increased the depth of anaesthesia. The chief asked for dabs and the theatre sister passed him a nasal speculum. "No, not that," he said and put some clamps on the stomach and laid the gastric mucosa wide open. Lo and behold, there lay a spanner! The dresser blamed himself for not enquiring more fully into her social history. He knew discreet enquiries into her husband's profession (he was a mechanic) would have cast light on the diagnosis. The H.S. rebuked himself for not suggesting an oesophagoscopy and knew his chances of becoming a big surgeon with a large car were not so good. The chief said that it was an unusual case and he would communicate it to the Royal College right away.

Everything turned out happily. Mrs. Brown had a long chat with the Lady Almoner who asked her "How many flights up do you live and how many steps do you have to climb?" Mrs. Brown said "Five flights and eighty-five steps." The Almoner smiled and said, "If you live for eighty-five years that would make a step for each year," but hastily withdrew her remark because she wasn't too sure of her arithmetic. Only radiotherapists have a good head for figures because they have to work out complicated X-ray dosages, while she had nothing to do except to provide occupational therapy for

patients and make sure they had enough money to get back home.

Mrs. Brown does not complain any more of having a spanner in her works. When I told him, the psychiatrist was so embarrassed that he changed the subject immediately. He doesn't take on any more cases which I refer to him.

CAMBRIDGE BART'S GRADUATES DINNER

*To the Editor,
St. Bartholomew's Hospital Journal.*

Dear Sir,

The recently held Cambridge Bart's Graduates' dinner was an outstanding success.

But many of us fear, however, that it might be the last dinner of this character that will ever be held, for inevitably the whole atmosphere of the dinner and speeches will change if we have women, in particular non-medical women, guests. The speeches, as is usual, were excellent, topical, reminiscent of the great figures of the past, and full of essentially medical humour which would be boring and even somewhat distasteful to a feminine audience; and in respect to their feelings, the

I hope you will publish these facts of the case before the chief gets a chance to put them into the Journal of the Royal College of Surgeons. I can't very well send you the spanner but you will find it in the pathological museum. There is a Sarcophagus there too, but that has nothing to do with it.

speakers in future will have to modify their wit to suit a mixed company.

This club has held its dinners for many years and is comparable with old school, college or regimental dinners, where friends who have enjoyed the advantage of a similar background can meet again. Surely women would not enjoy themselves and would be out of place at any of these dinners?

It was obvious that opinion at the dinner was very much against this innovation, and I think the very small majority at the ballot should not be enough to influence the Secretaries and Elder Brethren to take this drastic decision.

Yours faithfully,

WARREN A. BARNES.

PREPARATION OF MATERIAL FOR THE PRESS

The preparation of papers for the Press can be very complicated, but much time and trouble is saved if one studies the instructions to contributors printed in most scientific periodicals. These instructions differ considerably, and articles are liable to summary rejection if not prepared in accordance with the rules of the journal to which contributions are submitted. Spacing, the arrangement of references, and the abbreviation of titles of periodicals commonly cause trouble, and to assist students and staff in preparing material for the Press, the following are provided in both the Main and Charterhouse libraries:

A folder containing (a) "Instructions to Contributors," removed from periodicals taken in the Library (b) *A List of Abbreviations of the Titles of Biological Journals*, from the "World List of Scientific Periodicals," and (c) a sheet bearing the conventional signs commonly used when correcting proofs, to prevent misunderstandings with the printer.

This material should prove useful to authors, and the Librarian will be glad to assist further if required.

J. L. T.

WESSEX RAHRE CLUB

The Wessex Rahere Club will be holding a Spring Dinner at the County Hall, Taunton, at 7.30 p.m. for 8 p.m. on Saturday, April 29. Mr. J. B. Hume is attending as guest of honour. The Hon. Secretary of the Club is Mr. A. Daunt Bateman, 3, The Circus, Bath.

WARD ROUND AND OUTPATIENT TIMES

We trust that the lists of ward rounds and of times for attendance in the Out-Patients' Departments will be accurate at time of publication. When the present state of flux between Hill End and Bart's has resolved itself we hope to publish an amended list of ward rounds. Meanwhile we should be grateful for notification of any changes.

SPORT

RUGBY CLUB

HOSPITALS' CUP : FIRST ROUND

February 14 v. King's College Hospital, Richmond.
Result : Won 11 (1 goal 1 penalty 1 try)—9 (2 penalties 1 try).

King's attacked strongly and kept the Hospital well within their own half for most of the first ten minutes—during this time a number of penalties were awarded against the Hospital, and from one of these King's opened the scoring. Soon after this one of the King's centres slipped his opposite number and scored far out—the goal points were not added. Bart's now really started to get going and from a line out on the King's line Mears went over—the try was not converted. The Hospital kept up the pressure, and from a scrum on the King's line John scored, the goal points being added by Moyes with a really fine kick. Play was fairly even from now on, but just before half-time a penalty was awarded against the Hospital—the kick was successful. Half-time: Bart's 8 pts., King's 9 pts.

In the second half Bart's had the advantage territorially for a large proportion of the time, but there was little cohesion and they just did not seem to be able to finish off any movement. Fortunately for the Hospital, about ten minutes from the end, one of the King's forwards was off-side from a set scrum just outside his own "25." Moyes kicked a perfect goal to give Bart's a narrow, but deserved, victory.

HOSPITALS' CUP : SECOND ROUND

February 28 v. London Hospital, Richmond.
Result : Lost 21—nil.

London Hospital beat St. Bart's in the second round of the cup by 3 goals-and 2 tries (21 points) to nil. Bart's had more of the ball than the score would suggest, thanks to the grand work of the forwards, who were without Mears for the greater part of the match and Havard for the last ten minutes. The London backs showed superior speed and thrust in attack and defied the gallant efforts of the Bart's backs to hold them.

The game opened with vigorous open play from both sides, and London looked dangerous when one of their backs kicked ahead, but Stephens was the first to touch down. Gradually the London backs gained the upper hand and had scored three tries (all converted) by half-time.

After the interval the Bart's forwards took command, and, with frequent forward rushes, kept the ball in the London half, despite accurate touch-finding by the London stand-off half, Phillips. Dick, Havard and Stephens were well to the fore, and came close to scoring. The backs were also holding their own at this stage, but spoiled one very promising movement with a forward pass.

Gradually London returned to the attack, and were pressing strongly when Havard and Moyes collided. The former was bleeding too profusely to be allowed to continue and the latter carried on with a broken tooth.

London pressed home their advantage and scored two tries in the last five minutes, despite the efforts of the indefatigable Third.

The Bart's team was well beaten, but is to be congratulated on its grand spirit and "honest endeavour."

February 18, v. Old Leysians (home).

Result : Won 23—3.

February 25, v. O. Cranleighans.

Result : Lost 6—8.

HOCKEY CLUB

2nd Round Inter-Hospital Cup v. St. George's Hospital.

February 18, Won 3—0.

This match, played at Chislehurst, proved to be far more enjoyable for all concerned than is usual in a Cup match. St. George's opened well, and during the opening ten minutes harassed the Bart's defence considerably, gaining three short corners in quick succession. The home side, however, soon recovered, and their forwards began to show thrust and initiative, and it was no surprise when Dossetor opened the scoring from a short corner. The lead was increased shortly afterwards by Batterham, who, following up his own shot, forced the ball over the line, and, just before half-time, Godden received a long pass down the right wing, and went through on his own to give Bart's a three-goal lead.

After the interval Bart's forwards, well supplied with cross passes from their halves, continued to keep up their pressure, but fine goalkeeping by Jory of St. George's prevented them from increasing the lead. The St. George's forwards, though fast and clever, tended to hold the ball too long, thus playing into the hands of a safe defence.

Our thanks are due to J. W. Mellows for his help in umpiring, and to those spectators who gave us their support.

Other Results, 1st XI.

February 11, away, v. U.S. Portsmouth. Lost 2—3.

February 18, home, v. Middlesex Hospital.

Won 3—1.

February 19, away, v. Lansbury. Lost 2—4.

February 25, away, v. South Saxons. Lost 0—7.

CRICKET CLUB

Officers for the 1950 season:—President, Mr. J. E. A. O'Connell; Vice-Presidents, Dr. Geoffrey Bourne, Dr. N. C. Oswald, Prof. Sir James Paterson Ross, Prof. A. Wormall; Captain, J. A. Clappen; Vice-Captain, M. Braimbridge; Secretary, H. B. Ross; Treasurer, J. P. Waterhouse.

Watch the notice-boards during April for announcements about net practice, trial matches, etc.

GOLF CLUB

"Evening News" Tournament

The qualifying round for the "Evening News" Week-end Golfers' Tournament was held at Sundridge Park on February 22. There were 11 entries. The two players returning the best nett scores were D. Rushton 80—7=73, and M. Braimbridge 89—14=75, who thereby qualify for the match play stages.

CHESS CLUB

A Chess Club was formed last November with Dr. N. C. Oswald as its President. The club has entered the University of London Chess Club Leagues, Division II, and has won its first two matches (v. Goldsmith's College 5—1 and v. King's College II 4—2).

We expect to meet with much stronger opposition in our next two matches.

The club meets every Thursday at 5 o'clock in the small Abernethian Room at Charterhouse Square, except when there is an Abernethian Society meeting. All interested will be very welcome.

TIMES FOR ATTENDANCE IN THE OUT PATIENTS' AND SPECIAL DEPARTMENTS

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
*MEDICAL OUT-PATIENTS New Cases : 9 a.m.	Dr. K. O. Black 9 a.m. Dr. R. Bodley Scott 10 a.m.	Dr. E. F. Scowen 9 a.m. Dr. G. Hayward 10 a.m.	Dr. Neville Oswald 9 a.m. Dr. W. E. Gibb 10 a.m.	Dr. R. Bodley Scott 9 a.m. Dr. K. O. Black 10 a.m.	Dr. G. Hayward 9 a.m. Dr. E. F. Scowen 10 a.m.	Dr. W. E. Gibb 9 a.m. Dr. Neville Oswald 10 a.m.
*SURGICAL OUT-PATIENTS New Cases : 9 a.m.	Mr. Tuckwell 9 a.m.	Surg. Prof. Unit 9 a.m.	Mr. A. H. Hunt 9 a.m.	Mr. D. F. Ellison Nasl 9 a.m.	Mr. Badenoch 9 a.m.	Prof. Sir J. Paterson (Surg. Prof. Unit) 9 a.m.
*DISEASES OF WOMEN ANTE-NATAL.	Mr. John Beattie 9 a.m. (Gynaec & Ante-Natal)	Mr. J. Howkins 9 a.m. (Ante-Natal) Infertility Clinic 1.30 p.m.	Post-Natal Clinic 9 a.m. Dr. Wilfred Shaw (Gynaec) 12.30 p.m. Mr. J. Howkins 12.30 p.m.	Mr. Donald Fraser 12.30 p.m. (Ante-Natal)	Discharge Clinic 9 a.m.	Mr. Donald Fraser 9 a.m. (Gynaec)
*ORTHOPAEDIC DEPARTMENT	Mr. H. J. Burrows 9.30 a.m. (Fracture Clinic) Mr. H. J. Burrows 1 p.m.			Mr. S. L. Hogg 1 p.m. Mr. W. D. Collett 1 p.m.	Mr. W. D. Collett (Fracture Clinic)	
*EAR NOSE & THROAT DEPARTMENT	Mr. J. W. Cope 9 a.m.	Mr. F. C. W. Capps 9 a.m. Mr. C. G. Hogg 9.30 a.m. Mr. N. A. Jory 1 p.m.		Mr. J. C. Hogg 9 a.m.	Mr. N. Jory 9.30 a.m. Mr. J. W. Cope 9.30 a.m. Mr. F. C. W. Capps 1 p.m.	
*OPHTHALMIC DEPT.	Mr. Seymour Philips 9 a.m. Refraction Clinic 1.30 p.m.	Mr. H. B. Stallard 1.15 p.m.		Mr. Seymour Philips 9 a.m.	Refraction Clinic 1 p.m. Mr. H. B. Stallard 1.15 p.m.	
*SKIN DEPARTMENT	Dr. Charles Harris 9 a.m. Dr. A. W. Franklin (Babies under 1) 9.30 a.m.	Dr. Brian Russel 9 a.m.	Dr. R. M. B. MacKenna 9 a.m.		Mr. R. M. B. MacKenna 9 a.m.	
*DISEASES OF CHILDREN		Dr. Charles Harris (Children to 12) 9.30 a.m.			Dr. A. W. Franklin (Children 1 to 12) 1.30 p.m.	
DENTAL DEPARTMENT	Mr. G. A. Cowan 9.30 a.m.	Mr. G. T. Hankey 9.30 a.m.	Mr. J. D. Cranbrook 9.30 a.m.	Mr. G. A. Cowan 9.30 a.m.	Mr. G. T. Hankey 9.30 a.m.	Mr. J. D. Cranbrook 9.30 a.m.
TUBERCULOSIS DISPENSARY	2 - 4 p.m.	Men 9 a.m. - 6 p.m. Women 9.30 a.m. - 12.30 p.m. A.F. Clinic 3 p.m.	Men 9 a.m. - 6 p.m.	Men 9 a.m. - 6 p.m. Clinic 11 a.m. - 1.45 p.m.	Men 9 a.m. - 6 p.m. Clinic (Women) 11 a.m. - 1.45 p.m.	Men and Women 9 a.m. - 12 noon
MATERNITY & CHILD WELFARE (City Residents only)	2 - 4 p.m.	12.30 - 1.30 p.m. 3.30 - 7.10 p.m. A.F. Clinic 3 p.m.	2 - 4 p.m.		(By appointment only)	
VENEREAL DEPARTMENT	Men 9 a.m. - 6 p.m. Clinic 11 a.m. - 1.45 p.m.	Men 9 a.m. - 6 p.m. Women 9.30 a.m. - 12.30 p.m.	Men 9 a.m. - 6 p.m.	Men 9 a.m. - 6 p.m. Clinic 11 a.m. - 1.45 p.m.	Men 9 a.m. - 6 p.m. Clinic (Women) 11 a.m. - 1.45 p.m.	Men and Women 9 a.m. - 12 noon
*PLASTIC SURGERY				Dr. E. B. Straus 2 p.m.	Dr. E. B. Straus 2 p.m.	
*PSYCHOLOGICAL DEPT.		Dr. J. Aldren Turner 1.30 p.m.			Dr. J. Aldren Turner 1.30 p.m.	
*NEUROLOGICAL DEPT.		Mr. J. O'Connell 1.30 p.m.				
*NEUROLOGICAL SURGICAL DEPT.		Speech Therapist 1 p.m. Mr. Basil Hume 3.30 p.m.	Dr. E. R. Cullinan 1 p.m. (Gastroenterological) Mr. John F. Rosford 1 p.m.	Dr. Geoffrey Bourne 10 a.m. (Cardiological) Dr. E. F. Scowen 10.30 a.m. Mr. Rupert Corbett 10.30 a.m. (Endocrine) Dr. R. O. Black 1.30 p.m. Surg. Prof. Unit 1.30 p.m.	Prof. R. V. Christie 10.30 a.m. Dr. E. F. Scowen 10.30 a.m. Mr. Rupert Corbett 10.30 a.m. Dr. R. O. Black 1.30 p.m. Surg. Prof. Unit 1.30 p.m.	Mr. O. S. Tubbs 10.30 a.m.
*SPECIAL & FOLLOW-UP CLINICS						
RADIO THERAPY DEPT.	1.30 p.m.	1.45 p.m.	1.45 p.m.	1.45 p.m.		

* By appointment only with appointments department.

+ These hours are intended only for patients who cannot attend at mid-day.

† There is a daily Fracture Clinic at 9.30 a.m. attended by the Chief Assistant to the Orthopaedic Department.

WARD ROUNDS

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Prof. R. V. CHRISTIE		2.0 p.m. Bart's			2.0 p.m. Bart's	
Dr. G. BOURNE	2.0 p.m. Bart's	2.0 p.m. Bart's		2.0 p.m. Bart's	2.0 p.m. Bart's	
Dr. E. R. CULLINAN		10.30 a.m. Hill End		2.0 p.m. Bart's	10.30 a.m. Hill End	
Dr. A. W. SPENCE		2.0 p.m. Bart's				
Dr. E. F. SCOWEN	1.30 p.m. Bart's			1.45 p.m. Bart's	1.30 p.m. Bart's	
Prof. Sir J. PATERSON ROSS		1.45 p.m. Bart's			1.30 p.m. Bart's	
Mr. J. B. HUME		10.30 a.m. Bart's				
Mr. R. S. CORBETT	10.0 a.m. Bart's			1.30 p.m. Hill End		
Mr. J. P. HOSFORD		10.30 a.m. Bart's		10.30 a.m. Bart's		
Mr. C. NAUNTON MORGAN	10.30 a.m. Bart's			10 a.m. Hill End		
Dr. C. F. HARRIS		10.30 a.m. Bart's		10.0 a.m. Bart's		
Dr. A. W. FRANKLIN						
Dr. J. W. ALDREN TURNER	2.0 p.m. Bart's		10.0 a.m. Bart's			
Dr. W. SHAW						
Mr. J. BEATTIE						
Mr. D. B. FRASER						
Mr. J. HOWKINS						
Mr. S. L. HIGGS	10.0 a.m. Hill End (Alt. Mondays)					
Mr. O. S. TUBBS	3.0 p.m. Hill End (Alt. Mondays)					
Mr. J. O'CONNELL	2.0 p.m. Bart's					
Dr. R. BODLEY SCOTT						
Dr. K. O. BLACK						
Dr. N. C. OSWALD						
Dr. W. E. GIBB						
Dr. G. W. HAYWARD						
Mr. A. H. HUNT						
Mr. A. W. BADENOCH	10.30 a.m. Bart's					
Mr. E. G. TUCKWELL						
Mr. D. F. ELLISON NASH ..						
Assistant Director of Surgical Professorial Unit				1.30 p.m. Bart's	2.0 p.m. Hill End	

BOOK REVIEWS

BUCHANAN'S MANUAL OF ANATOMY.

Edited by F. Wood Jones. 8th Edition. Baillière, Tindall & Cox, pp. viii+1516, plates 48, figs. 847. Price 45s.

This new edition of *Buchanan* is essentially a re-issue of the previous (1946) edition; some necessary minor emendations have been effected in the text and in certain of the figures, but the pagination, format and illustrations remain unchanged. The policy of omitting colour from all illustrations has been maintained and proves, on the whole, to be distinctly advantageous. The superb radiographic plates merit a special word of praise.

This work remains the only satisfactory British textbook of anatomy arranged on a regional basis and its disadvantages are those inseparable from such an arrangement, principally the inevitable absence of a sufficiently informative introductory account of the several body-tissues and systems. Thus bone, as a tissue, receives such a traditional treatment, but not so muscle and nerve: nor is any general scheme of, for example, the important lymphatic system, capable of presentation. On the other hand, these inherent defects are offset by the copious and well-planned index, permitting rapid reference to any given structure or region, whilst the full and delightfully "easy" text provides an authoritative account of topographical anatomy unrivalled for lucidity and accuracy. So far as any anatomical treatise may inculcate a knowledge and an appreciation of human structure, this work does; the student who accepts its guidance to supplement his own work in dissecting room and laboratory will do so with profit and pleasure. Particularly valuable is the retained chapter—an innovation in the previous edition—on human growth and development. Not easily will the student glean elsewhere the information here assembled regarding the anatomical characteristics of infancy, childhood, puberty and adolescence.

Perhaps in a subsequent edition it will be deemed advisable to give details of the facial and vertebral musculature in smaller print and compass, likewise the traditional cabalistic divisions of the cerebellum, admitted by the text to be devoid of either physiological or morphological value. A useful addendum to the section on the central nervous system would be a diagram of the brain-stem nuclei and their principal connexions as seen in three-dimensional lateral view. The figure (Fig. 526) of the rectum and anal canal stands in need of correction, both pictorially and as regards labelling, whilst in Fig. 676 a more accurate demarcation seems desirable between the respective cutaneous territories of the ophthalmic and maxillary nerves. These however are very minor matters, in no way detracting from the general excellence of the work, which for accuracy and quality of descriptive style is its own recommendation.

A.J.E.C.

A TEXT-BOOK OF HISTOLOGY FOR MEDICAL STUDENTS, by Evelyn E. Hewer. Heinemann, 1949. 5th Edition, pp. viii+432, 418 illus. Price 25s.

It is perhaps too much to expect a preclinical student to carry a book such as Gray's Anatomy to each Histology class. Yet minute structure is

adequately described and illustrated therein. If 25s. can be spared, however, Dr. Hewer's book will provide the solution to this problem which is one of transport. Apart from this, it is undoubtedly the most satisfactory text-book for those who are later to study also the abnormal. The illustrations are lavish; the photomicrographs of acknowledged excellence and the drawings object lessons in how detail can be rapidly, simply and yet effectively represented. Does all this tend to "spoil" the student? The answer will depend on how one believes that histology should be taught and learnt, and what its place is in the present-day whirlwind before the 2nd M.B.

This new edition has been thoroughly (not "roughly" as misprinted in the preface) revised and yet more illustrations added; human material replacing some that was previously from brutes. This is ideal, but it is not always easy to obtain fresh, normal human material, and even that from the more edible brutes is nowadays guarded by restrictions that are somewhat irritating, considering the very small quantities required*.

Finally, may it be suggested that a picture of blood x385 means little to a student who is taught that the red cells average 7.2 in diameter? Nearly all books continue to give only magnifications against the illustrations. All can presumably read scale maps, and if Dr. Hewer, in her next edition, were to break with tradition and insert a simple scale with each picture, she would give the student a clearer and much more exact understanding of the size of microscopic struc-

UNIVERSITY EXAMINATION POSTAL INSTITUTION

17, RED LION SQUARE, LONDON, W.C.1
G. E. Oates, M.D., M.R.C.P., London

POSTAL COACHING FOR ALL MEDICAL EXAMINATIONS

SOME SUCCESSES GAINED BY OUR
STUDENTS 1936-1949:

Final Qualifying Exams.	544
M.R.C.P. (London)	216
Primary F.R.C.S. (Eng.)	219
Final F.R.C.S. (Eng.)	145
F.R.C.S (Edin.)	39
M.D. (Lond.)	65
M. and D. Obst. R.C.O.G.	225
D.A.	171
D.C.H.	127
M.D. by Thesis	Many Successes

PROSPECTUS, LIST OF TUTORS, Etc.,
on application to THE SECRETARY, U.E.P.I.,
17, RED LION SQUARE, LONDON, W.C.1.
(Telephone HOLBORN 4313)

tures. Furthermore, it would not then matter what size the original pictures were reproduced.
* *Lancet* (1949, ii. 1149.)

J. M. P.

OPHTHALMIC NURSING, by P. Garland. Faber & Faber, 1950, pp. 158, illus. 119, plates 24. Price 12s. 6d.

Miss Garland has a clear and simple style, and the information that she gives is just what the nurse wants to know. The photographs and diagrams are good.

We cannot agree that the front of the nurse's wrist is better than a thermometer for testing the temperature of a lotion (p.44). It should not be true in these days that the patient feels a "sudden sharp pain" at iridectomy (p.136).

GRAY'S ANATOMY, edited Johnstone and Willis. 13th Edition. Longmans Green & Co., 1949, pp. xix + 1,533. Price 84s.

It would be presumptuous to attempt to review the new edition of "Gray's Anatomy" and thus a note on the changes from previous editions is all that is required.

The whole work has been carefully revised and new matter added, but in spite of this the length has been reduced by sixty pages. This has been made possible by avoiding repetition, and has entailed the transference of matter on Surface Anatomy from its own section to that dealing with the part in question. This seems a praiseworthy innovation which should assist in the correlation between cadaveric and living anatomy.

The new illustrations are up to the high standard of those in past editions.

STEDMAN'S MEDICAL DICTIONARY, edited by N. B. Taylor. 17th Edition. Ballière, Tindall & Cox, 1950, pp. xlv + 1,361. Price 64s.

This American dictionary is, in spite of its spelling, of value to the British doctor. In the introduction is a list, for the benefit of those who lack the blessings of a classical education, of common Latin and Greek root words and their meanings. A useful table. In the text the derivation of words is stressed in detail. The dictionary itself is in very small, though clear, type, with the described words standing out in bold lettering—a striking method of presentation but worrying to the eye. Short biographical notes of famous men are useful inclusions.

BENNETT'S MATERIA MEDICA AND PHARMACY FOR MEDICAL STUDENTS, revised by H. G. Rolfe. 5th Edition. H. K. Lewis, 1950, pp. xxviii + 276. Price 16s.

The points of value and the faults of this book are better understood when it is realised that both the author and reviser are chemists. Consequently the rider "For Medical Students" is somewhat of a euphemism. Three-quarters of the text attached to each drug refers to formula, source and physical characteristics, and merely a quarter to the matters of real moment to the student, uses and dosage. The size of the book, however, is convenient, there is a useful table of substances in order of increasing dosages, and a good chapter on incompatibility. This is a book of more value to the pharmaceutical than the medical student.



8 Vitamins in Aqueous Solution

'ABIDEC' Drops

'Abidec' Drops may be taken directly on the tongue or mixed with milk in the feeding-bottle without altering appreciably either taste or appearance.

Dose for infants under 1 year, 15 drops daily;

for older children, 30 drops daily.

Each 0.6 c.c. (30 drops as delivered by the dropper) represents:—

Vitamin A.	5000 I.U.	Vitamin D.	1000 I.U.
Vitamin B ₁ .	1 mgm.	Vitamin B ₂ .	0.4 mgm.
Vitamin B ₆ .	0.5 mgm.	Pantothenic Acid	1 mgm.
Nicotinamide.	5 mgm.	Vitamin C.	25 mgm.

In 10 c.c. and 50 c.c. bottles, with dropper.

PARKE, DAVIS & COMPANY

HOUNSLOW, MIDDLESEX. Telephone: HOUNslow 2361. Inc. U.S.A., Liability Ltd.



trade
mark**'SONERYL'** brand butobarbitone

medium-acting hypnotic which, in varying dose, can be used as hypnotic or mild sedative. Almost entirely detoxicated by the tissues providing a wide margin of safety. Free from risk of habit formation. Sleep generally occurs within 30 to 40 minutes and lasts from 6 to 10 hours.

In **'SONALGIN'** brand *Propen* with codeine, butobarbitone is combined with phenacetin (analgesic and antipyretic) and codeine (analgesic). Used in relief of pain in such conditions as dysmenorrhoea, neuralgia, myalgia, fibrositis, toothache, migraine, etc. Well tolerated and may be given even in cases of exhaustion.

Intelligence Service

In those fields of therapeutics where there is greatest activity it is inevitable that standard textbooks are sometimes unable to keep pace with important new developments. The medical student who wishes to keep abreast of such developments but cannot spare the time to consult original publications will often find that the publications issued by manufacturers of new drugs are of considerable value.

Medical students are cordially invited to communicate with us whenever they feel we might be of help. Write, or 'phone ILFord 3060, ext. 99 or 100.

M&B Medical Products  are manufactured by

MAY & BAKER LTD

distributors

PHARMACEUTICAL SPECIALITIES (MAY & BAKER) LTD. DAGENHAM



WORKERS WITH MINOR INJURIES

The principle of "throwing" pottery remains the same as in Biblical times. But now-a-days the potter's wheel is propelled by an electric motor. Throughout the day the potter's hands are covered with soft clay; the possibility of injury is heightened by mechanisation. Cuts and minor injuries have to be protected without interference with work.

This is a constant problem for the Industrial Medical Officer, the Hospital Casualty Officer and the General Practitioner. Waterproof Elastoplast has been introduced to meet this problem and already has proved ideal for the initial treatment of injuries where the operative is in contact with liquids yet able to remain at work.

Waterproof Elastoplast is in free supply, in a range of sizes and packs. The Medical Department of the manufacturers will send you samples on request.

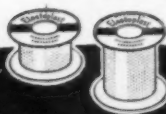
WATERPROOF

Elastoplast

**FIRST AID
DRESSINGS
AND PLASTERS**

TRADE MARK

Made in England by T. J. SMITH & NEPHEW LTD., HULL



**MEDICAL & FACTORY FIRST AID OUTFITS.
UNIT PACKS. 1 in. & 2 in. x 3 yds. PLASTERS**

ROTER

Roter Gastric Ulcer Tablets

indicated for:

GASTRIC AND DUODENAL ULCERS

No narcotics. No side effects

Rapid release from pain and discomfort

Easy oral therapy

Doctors with gastric or duodenal ulcers are invited to send for literature and a trial sample

Roter will usually be found effective where everything else has failed

F.A.I.R. Laboratories Limited

183 Heath Road, Twickenham

INTRAVENOUS ANAESTHESIA

with

'KEMITHAL' SODIUM

TRADE MARK

'Kemithal' Sodium is a highly efficient ultra-short-acting barbiturate used for induction and surgical anaesthesia of short or prolonged duration. Notable features of its uses are minimal respiratory depression and a consistently good post-operative recovery, free from vomiting, restlessness and protracted depression.

Ampoules of 1 or 2 grammes, with or without distilled water.

Containers of 5 and 25.

Literature and further information available, on request, from your nearest I.C.I. Sales Office—London, Bristol, Birmingham, Manchester, Glasgow, Edinburgh, Belfast and Dublin.

IMPERIAL CHEMICAL (PHARMACEUTICALS) LIMITED

A subsidiary company of Imperial Chemical Industries Limited

WILMSLOW, MANCHESTER



Ph. 110

W. H. BAILEY & SON LTD.

**SURGICAL
INSTRUMENT
MAKERS**

**BAILEY'S
CLINICAL THERMOMETERS**
*Every Thermometer is
guaranteed, clearly marked*
1/2 Min. Mag. 3/6 each



SOLID STEEL SCALPELS. 4/6 each

STETHOSCOPES



D. 1203. BINAURAL STETHOSCOPE
Wide Chestpiece with Thumb Rest. 25/- each



SC 1692
Head Mirror
on Web Band
Size 3 1/4" dia.
Centre hole ... 25/- Other patterns from 16/6

**WHY NOT SEND
YOUR REPAIRS
TO US?**
SCISSORS, SCALPELS
KNIVES of all descrip-
tions and RAZORS
Ground and Set.
HYPODERMIC
SYRINGES repaired
LOWEST PRICES

Hospital
and
Invalid
Furniture



BAILEY'S DIAGNOSTIC SETS D. 1081 consisting of May's Ophthalmoscope, Auriscope, with 3 Specula, Duplay's expanding Nasal Speculum, Angular Laryngeal Lamp and two Mirrors, Tongue Spatula and Handle with Rheostat to fit the above instruments, complete in case, with spare lamp. **PRICE** complete £7 2 6. Auriscope, with 3 Specula, small battery, handle and spare lamp in case £3 0 0

**PRICES RULING AT
DATE OF DESPATCH**

10% DISCOUNT
Allowed to Students
mentioning this Advert

GERrard 3185 45 OXFORD STREET
2313 7 RATHBONE PLACE

LONDON, W.1

**SUPPLEMENTARY
UNITS**
help the young man
over the
Financial Stile!



FOR LESS THAN £1 PER
MONTH (ranking for Income
Tax Relief) . . . a healthy life
aged 30 can secure life cover of
£1,000 carrying with it valuable
conversion rights.

CM&G

**Supplementary
UNITS POLICY**

**Clerical, Medical & General
Life Assurance Society**

Chief Office:

15 St. James's Square, London S.W.1

Telephone: **WHitehall 1135**

City Office:

36/38 Cornhill, E.C.3.

Telephone: **MANsion House 6326**

**THE
MUNDESLEY
SANATORIUM
NORFOLK.**

Resident Physicians :

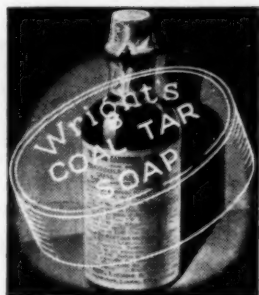
E. C. WYNNE-EDWARDS, M.B. (Cantab.),

F.R.C.S. (Edin.)

GEORGE H. DAY, M.D. (Cantab.)

Terms from 10½ guineas weekly

For all information apply the Secretary :
The Sanatorium, Mundesley, Norfolk

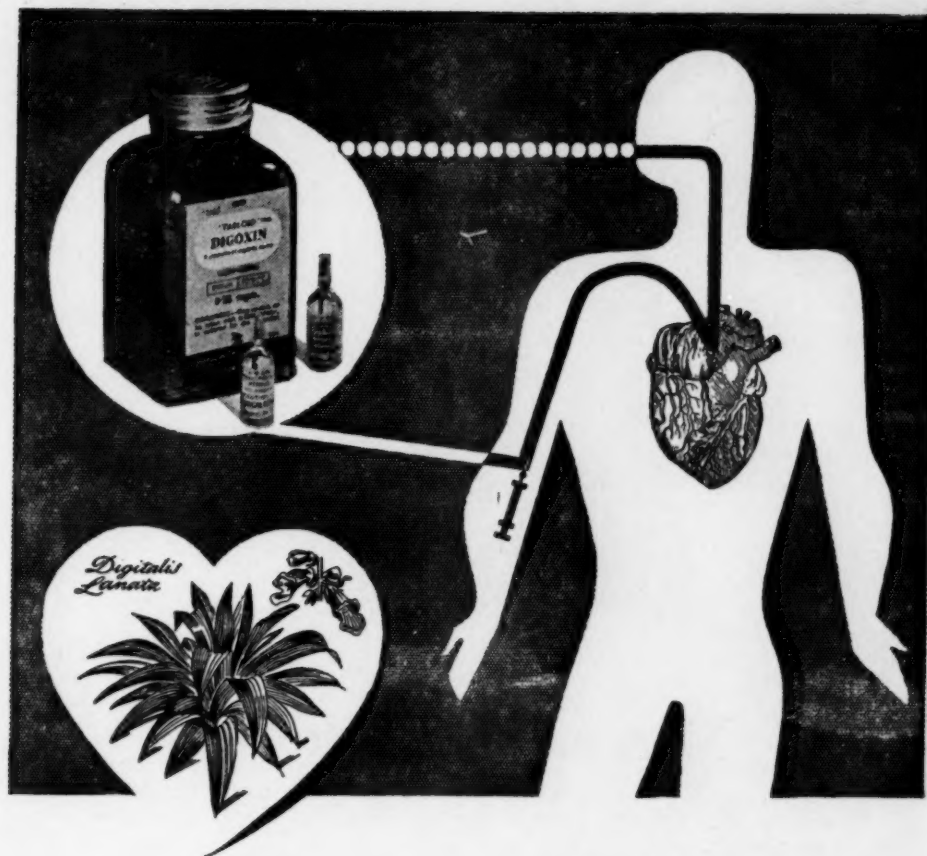


*The
principle
behind*
Wright's
*Coal Tar
Soap*

For over 80 years Liquor Carbonis Detergens has been used and recommended by specialists in skin diseases because of its antiseptic and antipruritic powers. Today those powers are more effective than ever before, thanks to continuous laboratory research and much improved methods of manufacture. Based on this therapeutic principle, Wright's Coal Tar Soap, mild and soothing in action, gives health protection to the skin.

IDEAL FOR TOILET AND NURSERY





SAFETY and CERTAINTY

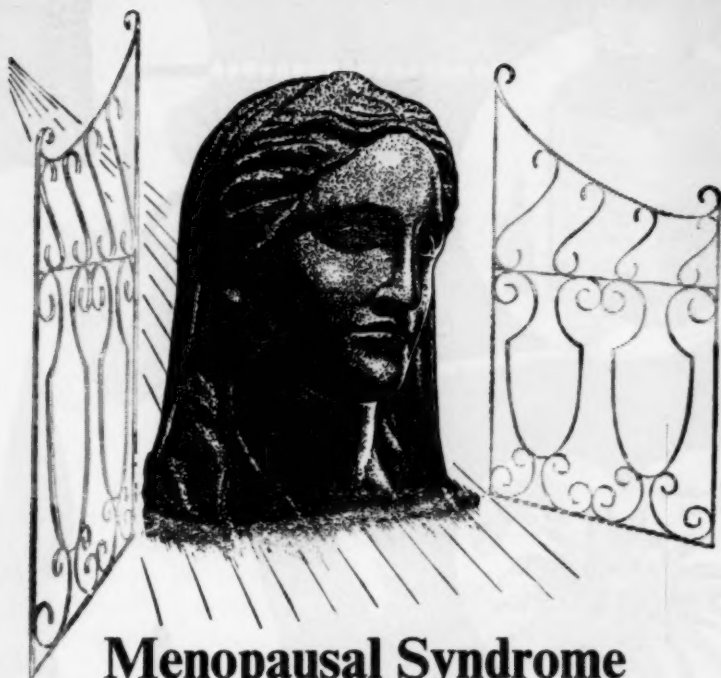
For initial digitalisation or for maintenance, Digoxin produces the desired result quickly, safely and with certainty. Being a single crystalline glycoside of definite composition and potency, it ensures a degree of accuracy unattainable with digitalis leaf products. Orally, Digoxin is effective in a few hours; intravenously, in a matter of minutes. It is particularly suitable for maintenance in the ambulant patient because the dose may be adjusted precisely, and risk of toxic effects is reduced.

'Tabloid' brand Digoxin, 0.25 mgm., for oral use; 'Wellcome' brand Sterile Alcoholic Solution of Digoxin (for the preparation of Injection of Digoxin).

DIGOXIN 'B.W.&CO.'



BURROUGHS WELLCOME & CO. (The Wellcome Foundation Ltd.) LONDON



Menopausal Syndrome

Estigyn enables the symptoms of the menopause, due to decline in the oestrogen secretion of the ovary, to be effectively treated by specific replacement therapy.

Estigyn is a highly potent oestrogen derived from natural sources and is active orally. In addition it is non-toxic in therapeutic doses. The improvement in subjective symptoms and the restoration to normal outlook is, in many cases, gratifyingly rapid while at the same time the possible onset of pruritus vulvæ or kraurosis vulvæ is prevented.

ETHINYL ŒSTRADIOL B.D.H. 'ESTIGYN'

*Tablets of 0.01 mg., 0.05 mg. and 1 mg. in bottles of 25 and 100
Literature and clinical samples available on request*

MEDICAL DEPARTMENT
THE BRITISH DRUG HOUSES LTD. LONDON N.1
TELEPHONE: CLERKENWELL 3000 TELEGRAMS: TETRADOME TELEX LONDON

Shoe/E/199